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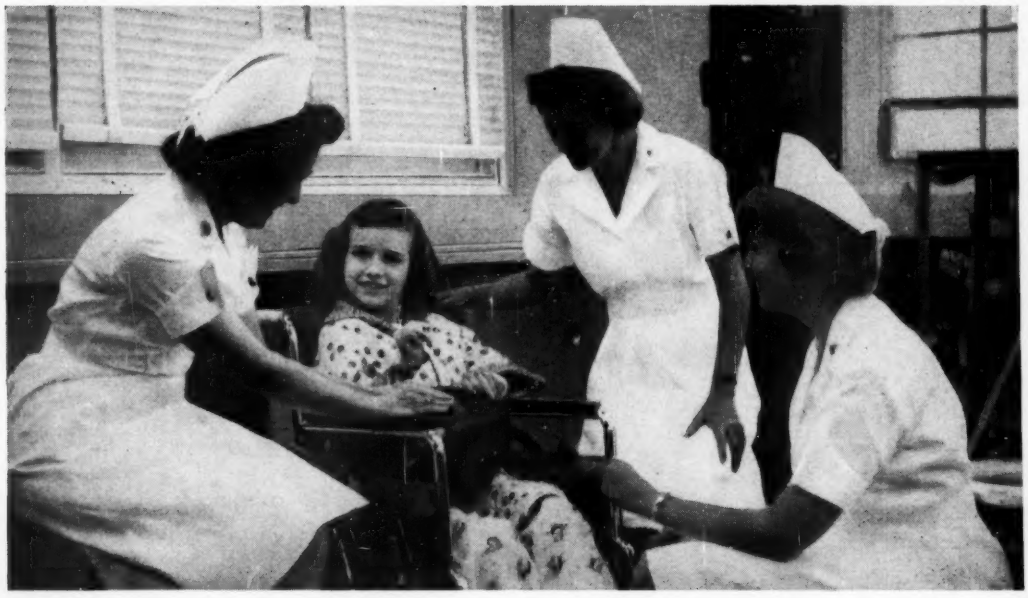

OCCUPATIONAL THERAPISTS IN THE ARMY MEDICAL SPECIALIST CORPS. Major Maryelle Dodds, Captain Janet Werner, and 2nd Lt. Judith Ouradnik, left to right. Their careers reveal the range of opportunities in the AMSC for selected college graduates. Photographed at Walter Reed General Hospital, Washington, D. C.

Major Maryelle Dodds' career ranges from the 98th General Hospital, Neubrucke, Germany, to the University of Southern California, where she received her master's degree. She has been an instructor at the Army Medical Service School, and a civilian instructor at Ohio State University.

Major Dodds is currently Chief Occupational Therapist at Walter Reed General Hospital. Here, she coordinates all occupational therapy activities, assigning and supervising her staff to provide professional treatment for all age groups, both male and female.

In a varied career as an Army occupational therapist, Janet Werner ranks her present assignment among the most challenging. Currently, she's supervising the O.T. Clinical Affiliation at Walter Reed General Hospital, one of the four hospitals where the program is conducted.

Captain Werner guides newly commissioned officers through an intensive professional program. It includes supervised treatment of patients, ward rounds, field trips, observation of surgical procedures, lectures, conferences, and staff meetings. The program begins in March and August of each year.

After graduating in June 1959 from Mount Mary College in Wisconsin, Judith Ouradnik entered the Army's O.T. Clinical Affiliation Program. She was commissioned a 2nd Lt. for a period of 24 months, and began her affiliation at Brooke General Hospital, San Antonio, Texas, completing it at Fitzsimons General Hospital, Denver, Colorado.

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SENSORIMOTOR INTEGRATION
A Basis for Planning Occupational Therapy

BEVERLY L. TROYER, M.A., O.T.R.

INTRODUCTION

The development of the human individual into a coordinated, active, perceptive and thinking organism requires precise integration of what are referred to as the sensory and motor systems. This integration or "unifying of different elements into a single whole"[1] occurs through the processes of maturation and learning. The occupational therapist is a participant in the integrating process, as it affects the patient, when an attempt is made to teach a sensory or motor skill. It is important, therefore, that the therapist have an understanding of how what he does with his patients fits into the total scheme, so that each individual with whom he works is being assisted toward the development of skills which will make him a more successful and productive person.

The purpose of this study is to organize some of the facts related to sensorimotor growth in an effort to set up a system which can be utilized in patient evaluation and training in occupational therapy. It is hoped that this will assist the therapist in gaining a clearer picture of what the patient's needs are and how they can be more adequately fulfilled.

In occupational therapy for cerebral palsy, where the author's previous experience was attained, a patient was evaluated and treated on the basis of a basic motor skill, activity evaluation and activities of daily living test. From these, it was possible to discern if the patient could grasp, cut with scissors and put on his shirt. If the patient could not do these things, then the therapist knew that these activities were still to be trained. This however, did not give the therapist any basis for judging how to correlate one activity with another, particularly in a field of work which recently has been influenced by several different neurophysiologically based treatment techniques. There also seemed to be no clear cut definition of what a basic motor skill or activity was. This study developed out of these problems.

Part I
APPROACHES TO THE PROBLEM

Patterns of growth. The first approach to this problem was to study the phylogenetic and ontogenetic development of a normal child which led to a long listing of skills taught in occupational therapy ordered by age level of development. From this study of development it was possible to set down what seemed to be underlying principles of growth. These were: (1) body structure is ready for function prior to the time when function actually begins, (2) many temporary patterns of behavior prepare for more permanent patterns, (3) there are definite directions in which growth processes proceed, and (4) there is an interaction of the different preparatory stages of activity.

Through the study of development it was recognized that much more precision in the evaluation of a patient was needed. It was also apparent that these principles represent functional aspects of development which occur as neuronal organization matures. The next approach to the problem, therefore, was to delve into the neurophysiological basis for motor and sensory "skills."

*A summary of a thesis presented to the faculty of the graduate school of the University of Southern California in partial fulfillment of the requirements for the degree of master of arts (occupational therapy). The author wishes to acknowledge the assistance of the Office of Vocational Rehabilitation for the grant which made this study possible.

Sensorimotor development. Through exploring the neurological and physiological bases for sensation and movement, it became apparent that there is a definite sequence through which sensorimotor behavior passes.

On the sensory side of the scale, the person first learns to understand the quality of sensation: pain, touch, temperature, stretch and tension of muscles, pressure, sound, light, taste, smell, position in space, and direction of movement, which are organized at the thalamic level of neural development.[2] This is followed by a primary cortical level which allows the individual to discriminate or tell the difference between different intensities, durations, and locations of sensation.[3,2] Discrimination is controlled by cerebral selection which is often referred to as attention.[4,5] The final step, a higher cortical level, is for the individual to identify or use his previous knowledge of sensation in a conceptual way in order to combine the knowledge he has of the several characteristics of a sensation, or in more complex form, several different sensations combined. An example of the latter is seen in stereognosis where a combination of proprioceptive and cutaneous impulses is utilized.[6,4,5]

The motor development begins with the spinal level of function represented in man by the protective reflexes, providing two general patterns of movement, one of flexion and the other of extension. The second stage is the development of postural equilibrium which is characterized by organization of the flexion, extension reflexes at the hind brain level, changes in posture representing preparation for action, and adjustments made by the body to maintain balance, and which is controlled by the action of the bulboreticular areas of the brain assisted by proprioceptors and visual cues. In the higher stages of motor development it is believed that the motor cortex controls discrete movements; the premotor cortex, patterned movements; the ideomotor area, the sequence of movements; and the frontal lobes, the planning of how activity is to take place.[7]

Out of these stages of sensation and motion, coordination emerges. Coordination represents a synchronous integration of the nervous system and is observable in movement which is precise and rhythmical. It means that the body is acting as a functional unit. There is adequate sensory input to stimulate impulses to travel through the nervous system in such a way that the components of motion which are wanted are facilitated and all else is inhibited. Also, that which is facilitated is held in check so that it occurs in the right degree to accomplish the precision of movement that is required.

Sensorimotor learning. The final approach to the problem of this study was to investigate learning as it specifically applies to sensation and motion in order to find out how development takes place. Munn has stated "skill as such is proficiency in the performance of some task."[8] If the therapist is to evaluate and train the patient in a sensory or motor skill, he must have some understanding of how skills are acquired.

In the nervous system there are several kinds of connections. The first is the unconditioned reflex, in which there are direct connections between motor and sensory aspects which come about through maturation. The others: the conditioned reflex which represents connections in which the individual is prepared to act with the first stimulus and responds with the second, and the connections in which ideation is present, representing stages in which learning takes place. Ideation occurs when the activity of the individual cannot be predicted by any sensory stimulation that is occurring at the same time as the activity or just before it, and is possibly due to cortical selectivity of both sensory input and motor output. Hebb has contributed a theory which makes these processes more plausible.[4,5] He suggests that these connections which have to do with learning are first developed into a cell-assembly or "a group of neurons arranged as a set of closed pathways,"[4] so that there is a circuiting of an impulse, with a fairly long delay between stimulus and response. This happens slowly by a development process, usually in infancy, as the result of repetition of a particular kind of sensory event. This seems analogous with reflex conditioning. Hebb stated that those assemblies which are active at the same time form a single assembly. When the assembly is active at the same time as an efferent pathway from the same region, the tendency is for the motor components to be incorporated into the assembly.[4,7] This gives a basis for set or cortical selectivity of motor output to occur. Hebb then explained that each assembly is related to a very simple sentory input so that it would be necessary for more than one assembly to be active for a perception to occur. Related to this is his suggestion that phase sequences, or series of assemblies are the means of transmission in the cortex.[4,5] This is not a direct transmission but one in which there are various closed circuits allowing for a "holding" of the impulse while traveling in particular patterns of connections. This then allows for an organization in terms of time which makes it possible for a response to occur when there is no stimulation occurring at the time which is related to it. Hebb's theory suggests that what is commonly referred to as memory or what is learned and stored are patterns of connections.[4,5] It also implies that in any learning, the earlier stages are accomplished through conditioning while

the more advanced learning is the result of perceptual processes in which patterns set up by previous conditioning may be utilized by combining patterns.[4,5]

Motivation seems to be the force which when present causes learning to continue to take place. In early learning it is an energizing force developed from the primary needs, those connected with stimuli causing pain, hunger, thirst and so forth. In later learning motivation is a guiding factor which is formed from secondary needs of a social nature, involving affiliative, status and acquisition needs.[9]

The organization of the learning experience is efficient when the schedule of practice is planned according to the type of activity and conditions involved, when the learner's attention is trained upon only the relevant stimuli, when the learner has been allowed to know how he is progressing, and when transfer is utilized.[3] Guthrie suggests that transfer is possible when there are common elements in a task already accomplished and the new one being learned.[10] Prevention of inhibitory stimuli and review of that which has been learned helps the learning to be retained once it has been accomplished.[3]

Thus far, three approaches to the facts related to sensorimotor growth have been made, through a study of growth and development, by assessing the processes involved in sensation and motion and by examining learning as it relates to this problem. Having done this, it is now possible to propose an organized manner in which the preceding information can be meaningfully used by the therapist.

Part II

THERAPEUTIC USE OF SENSORIMOTOR INTEGRATION

A concept of skill development. In organizing the facts relevant to treatment of a patient, the occupational therapist must have some means of judging what the patient is able to do and what the goals for future doing should be. In order to do this a concept of normal skill development is now presented with suggestions for translation to use with the disabled.

It is recognized at the outset that no two individuals are alike in their behavior. It has, however, been found that normal individuals, when studied from a growth and development vantage point, do, with certain variations, behave in sequential ways as they grow and develop. This has led to the observation and recording of growth and development norms by Gesell, McGraw and others. In view of what is known about the sensory and motor systems, and the suggested principles of growth and development, it now seems possible to suggest the stages that a person goes through in the development of purposeful activity. Stage one is the development of basic posture. Basic posture is here defined as the first complete function which the portions of the body attain, in which the nervous system connections allow the individual to do head balance, sitting balance, standing balance, flexion and extension of the arms and positioning of the hands. It should be recalled that one of the principles of growth and development suggested was that each function of the body develops out of several temporary developmental patterns in which the nervous system establishes the connections necessary to make the eventual permanent pattern possible. Basic posture represents the first formation of a permanent pattern. It is made up of temporary patterns in which there is sensory stimulation followed by reflex action. For example, trunk balance comes as the result of the development of sensation followed by primitive flexion-extension reflexes, followed by more complex postural reflexes, and finally a combining of these reflexes with those acting on the head. This first stage of basic posture must be attained before any succeeding stages can be accomplished.

Stage two in the development of purposeful activity consists in the learning of basic motor skills either for locomotion or manipulation. This can be exemplified by the following: Manipulation of objects is characterized by specialization of eye-hand function which can be broken down into parts known as grasp, retention, release, fix, follow and focus. These develop following the accomplishment of basic posture or positioning of the arm, hand, head and eye.

It is the parts or steps in learning the basic motor skills which Gesell must have had in mind in presenting his "stages of development of function."[11] He said, "The Prenascent Stage consists of complete absence of function."[11] This should need no further explanation. "The Nascent Stage is made up of imperfect, sporadic manifestation of the function in loose and variable association with several postural sets."[11] In the terms used in this paper, this means that at this stage the sensory and motor activities which occur together are beginning to build cell-assemblies. In the training of release of an object from the hand, this stage is exemplified by an attempt to open the fingers which is generally assisted by placing the object in the hand against something solid so that the object can literally be pushed out through leverage, forcing the opening of the fingers and the occurrence of the desired pattern. Next, "The Assimilative Stage is composed of more positive perfection of function which, however, is dependent upon particular postural sets, and accessory reinforcing attitudes.[11] Here, some circuits are still being rein-

forced by trial and error or random activity in which the motor and sensory activities which are being reinforced happened to occur together. There are separate, distinct parts to the movement and it can be done only in the posture in which it was learned. Returning to the example of release of an object from the hand, the fingers can now be extended but often they are not simultaneously extended. Sometimes, at this stage, the extension is too great and sometimes too little so that in effect the object is dropped from the hand, with the motion of the hand at the wrist at times entering into the picture. "The Coordinating Stage results in perfected performance limited to these particular postural sets but with sloughing off of the accessory postural attitudes previously necessary."[11] The performance has been perfected to the point that the circuits or cell-assemblies have been definitely established so that random activity no longer occurs. In the release of an object from the hand, there is now precision of movement so that the object is actually placed where it is to go at the time when it is to go there, as for example the placing of one block directly on top of the other, or the dropping of a pellet into the opening of a bottle. This activity would still be done with ease only in the position in which it was learned. Finally, "The Stage of Synergic Individuation is observed in the independence from restricted postural sets; versatile performance is smoothly synergized with numerous and varied postural sets."[11]

The movement is now smoothly executed so that none of the separate parts is discernible. It can be accomplished in a variety of postures. The several circuits or cell-asemblies have become related or a phase sequence has been established. The release of the object from the hand can now be done in a variety of positions. It can be done with varying sized objects and is now incorporated into a more complex activity such as that of throwing a ball.

The third stage in the development of purposeful activity, in which later learning is done, is the development of "achievement" activity. In this stage, the individual combines the basic motor skills which he has learned into activities or complex acts such as the throwing of a ball, or a woodworking project.

The fourth and last stage in the development of purposeful activity is the occupation stage. In this stage "achievement" activities are used in combinations which allow the normal adult to do such highly specialized activities as are required in an occupation. The ability to achieve a lifework develops out of the combinations of many previously learned skills.

Using the concept of skill development in treatment. Disability causes a lack of functional unity or a disintegration of function. If the occupational therapist is prepared to evaluate the patient's needs on the basis of the organized skill hierarchy, he would be able to determine at what point in the scheme there has been a breakdown. If the natural progression of skill development is followed in rebuilding the patient's abilities, there should be success in the re-integration. There will be success to the point that the disability is correctable. It is essential in the rebuilding process that each step in the skill development be included. If one step is skipped there can be one of several results: abnormal patterns of development, a loss of patient motivation, or a cessation of ability due to lack of development of the necessary nervous system connections. In carrying out the needed rebuilding of skill, the therapist would direct and control the therapy situation by use of the neuro-muscular mechanisms such as facilitation and by use of teaching methods conducive to the learning of skill.

CONCLUSION

An attempt has been made to order the facts about sensory and motor development to gain a meaningful concept of how the occupational therapist can utilize sensorimotor integration to administer activity to the disabled. Much more research is needed on how to utilize the neurophysiological mechanisms, how to motivate the patient, methods of teaching sensory and motor skills, and the surface has scarcely been touched in exploring interests, aptitudes and achievement as they relate to therapy.

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SOME EFFECTS OF SENDING PATIENT PROJECTS TO RELATIVES†

CLARENCE GROTH, M.S.W.*
JAMES DU PONT, O.T.R.**

Occupational therapists as part of the therapy team in a neuropsychiatric hospital seek to restore each patient to his best level of functioning with the goal of helping him to again take his place in the community. They are gratified, as are other team members, whenever this goal is reached. There are, however, in most mental hospitals a hard core of chronic long-term patients. Most of these patients do not respond well to any therapy and they seem to have little possibility of leaving the hospital because of lack of family interest.[1,2,3,4] Often they are, for the hospital staff, the less rewarding patients with which to work and tend to receive less attention than more responsive patients.

The authors of this paper became particularly interested in the estrangement of many of these patients and their relatives as shown by infrequent visits and letters when it is generally conceded that active interest of relatives can be beneficial.[1,2,3] Letters of various kinds have been tried to stimulate relatives to visit and write the patients and the hospital;[3,5] however, there did not seem to be any reports in the literature concerning the sending of OT-made articles to relatives for this purpose. We then planned this study to determine whether sending projects made by patients in occupational therapy to their relatives might help reactivate the relationships between the patients and the important persons in their lives.

The study was done at the Veterans Administration Hospital, Fort Lyon, Colorado, which is a 681 bed hospital for the treatment of mentally ill veterans. It is somewhat isolated in that the nearest population center in excess of 15,000 is located 100 miles to the west. This location presents some difficulty to visitors, especially those using public transportation.

DESCRIPTION OF THE SELECTED GROUP

The plan was to study a group of 50 male neuropsychiatric patients currently receiving occupational therapy who had not been visited for at least one year and had not received a letter from relatives for at least three months. However, it was only possible to obtain 34 such patients in the two participating occupational therapy clinics; the main reasons were that some patients were unable or unwilling to participate. In selecting the study group it was noted that although many patients were unvisited for one year, a considerable number of these had received letters or packages at infrequent intervals, usually on holidays and birthdays.

The average age of the 34 patients was 59.4 years and they had been hospitalized for an average of 18.4 years at the time of the study. Eighteen of the 34 patients' next-of-kin who were sent gifts lived farther than 500 miles from the hospital; 16 lived within 500 miles distance. Eight patients had never been known to have a visit from a relative since their admission to the hospital. The remaining 26 had not had a visit for an average of 5.3 years. The most frequently listed next-of-kin was a brother or sister in 19 out of 34 cases. This was followed by a child in five cases, a parent in four, and all other relatives in six. More than half, or 18 of all these patients, were single, ten divorced, four married, and two widowed. Twenty-four, or 71 per cent were diagnosed as schizophrenic, the balance as organic.

METHOD AND RESULTS

Two occupational therapists who worked in separate clinics agreed on standard articles to be made and sent home by patients. The first articles were ready in June of 1959; they were simple pot holder hangers and were sent to a relative of each patient. Usually it was the relative listed as next-of-kin in the hospital records. The second articles were reed baskets and were sent during December of 1959. It was hoped to have a third project, but the original group had dwindled because of ward transfers and changes in assignments. If the relative who received the article contacted the patient or the hospital within three months of the time the article was sent this was considered a response.

On first examination the response of the relatives seemed discouraging, but on closer study it was discovered that there were 18 responses in the form of packages, letters, and one visit. Considering that the patients in the study were older, long-hospitalized ones, and who apparently had little previous communication with their relatives, the 18 responses from the chosen relatives of the 34 patients were considered encouraging.

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**Chief, occupational therapy, Fort Lyon.
†The authors wish to thank Helen Bonnett and Janet McCall, O.T.R.'s, for their assistance in carrying out this project and Hiram L. Gordon, Ph.D., for his helpful comments and criticisms.

In comparing the characteristics of the 18 patients for whom a response was received with the 16 who did not receive a response, only one significant difference was noted. Those whose relatives lived close to the hospital received more responses. Twelve of the 18 responding relatives lived within 500 miles of the hospital, while only four of the 16 non-responding relatives lived within 500 miles of the hospital. By chi-square this difference was significant at the .05 level. This difference might be explained in terms of distance to travel for a visit but the cost of postage for a letter did not vary within the distances involved.

The two therapists' comments on the progress of the work and the patients' reactions to it were alike in many respects since both groups of patients were quite similar as to age and length of hospitalization. But two different personalities working in different occupational therapy clinics and with groups of patients from two different wards resulted in some divergences of opinion as to both the relative level of performance of the patients and the adequacy of the finished product. The following is a resume of the therapists' comments on the work involved in the project:

A small wooden or ceramic project (pot holder hanger) was presented to each patient and he was asked if he would like to make one to send to a relative. Some refused to accept the idea: "I have no relatives, I am the only one," "They don't care for me and I don't care for them," "I would rather do something else," and just "no" were their typical responses. One of these patients was later persuaded to participate but he was not particularly interested in it. Two became emotional and almost shed tears while talking about their relatives. Three very regressed patients agreed to the project but it probably had little meaning to them.

The patients were encouraged to do as much work as possible on the project. Very few were able to use the power jig saw by themselves, but each one who worked on the wooden article sanded and painted it and, with some help, wrapped it for mailing. All but two addressed their own packages, although many had to be rewritten to make them legible. The patients worked individually on this project and the packages were mailed as soon as completed, with each patient carrying his own package to the post office. A small number of the patients voluntarily reported that they had received a letter from relatives in response to the present. When others were asked they answered in the negative and it seemed to have little meaning to them; several did not seem to remember having sent a package.

The second article (a reed basket) was done as a group project in so far as possible. Patients in the same group worked together at a table; occupational therapists and assistants spent as much time as possible with them, helping individual patients and encouraging conversation. This attracted others who were not in the study and one group became too large to work with effectively. Also, it was not always possible in a group to explain to a patient why he should take out part of his work to correct a mistake. Slow workers tried to keep up with fast workers and the quality of the work was difficult to maintain.

Working in these groups, the patients willingly made the second article and seemed to enjoy the work more. Most of them showed passive interest in sending the projects home but later several were quite pleased when they received letters from relatives specifically thanking them for the gifts.

DISCUSSION

Although the apparent responses from relatives to patients as a result of this study were not outstanding, we believe these results alone were sufficient to make the study a worthwhile occupational therapy activity. After months of little or no communication between these patients and their relatives the responses could be utilized by the hospital personnel and the patients as a first step in re-establishing the relationships. If this technique were used routinely to stimulate communication between patients and relatives, and not as part of an experiment, the number of responses might be increased by enclosing a card stating the article was made by the patient himself and that a letter of acknowledgement might be helpful.

We found that some of the patients developed an interest in the study activity. This interest was not always evident at first; in fact, many of the patients had to be helped by the therapists through a period of initial resistance. This is not surprising as resistance to change is characteristic of many NP patients. However, once through this initial phase of resistance, we believe that some of these patients were able to function at a slightly higher level. They seemed able to work with less assistance from personnel and showed increased skill in forming inter-personal relations within the occupational therapy group setting.

This increased participation by the patients may have been a result of the added attention given by the occupational therapists during the study. Whatever the reason for more interest on the patients' part, the study afforded them an opportunity to do the same common activity as a group and acquire a semblance of group spirit. This might produce lasting values in terms of increased group activity skills and help counteract the usual trend toward isolation found in chronic regressed patients.

As a result of the study there were also some positive effects on the therapists. They had the specific goal of helping re-establish communication between the patient and his relative.[6] The therapists could make positive efforts in this direction instead of just hoping that in some way the patient-relative relationship would improve. This served as a stimulus for the therapists to exert renewed effort to motivate and further activate these patients.

(*Continued on Page* 81)

EXPERIMENTAL ATTITUDES AFFECTING BEHAVIORAL CHANGES IN NEUROPSYCHIATRIC PATIENTS*

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Research in occupational therapy with psychiatric patients has fundamentally been in the areas of technical aspects and meaning of therapeutic activity. Basically, the therapeutic aims have been to achieve adequate adjustment to environment through relief of prominent psychiatric symptoms. This approach is based on encouragement of suppression or expression of guilt feelings, hostility, and development of socially acceptable behavior patterns. It is proposed that these goals are not achieved merely through occupational activity, but that the essential factor in successful therapeutic endeavor consists of the relationship between patient and therapist through development of interpersonal skills which accompany both the conceptual and the motor activity. Very little information is available on the relationship of experimentally controlled attitudes of therapists to progress in occupational therapy. Recently, a need for more objective approach in occupational therapy research has been stressed by Reilly.[1] Utilization of scientific method of inquiry by employing experimental manipulation of punctate variables was also emphasized by Mowrer.[2] The final aim of any psychiatric treatment program is to change certain inadequate behaviors and the ultimate effectiveness of treatment must be contingent on overt behavior in an environment.

This study was designed to investigate the relationship of certain basic therapist attitudes in occupational therapy to objectively measured behavioral factors and to traditionally used progress note evaluations. It is generally accepted that, depending on the nature of an individual's pathology, therapists adjust their attitude to accomplish the most efficient and workable interpersonal relationship. The choice of attitude is usually on subjective basis, and is contingent not only on a patient's symptomatology, but also on subjective preference of therapists, mediated by their own needs and personality attributes. It was also hoped to determine in this study what types of attitudes are most effective in relation to three general groups of diagnostic categories of psychiatric patients. These categories were: (1) paranoid schizophrenic, (2) schizophrenic (other than paranoid), and (3) chronic brain syndrome patients (regardless of etiology).

METHOD AND PROCEDURE

There were 146 neuropsychiatric patients used in this study. At the time of the study the patients were currently assigned to one of the five occupational therapy clinics in a large 1176 bed neuropsychiatric hospital. Each patient was randomly assigned to one of the four attitude groups. The attitudes applied by the therapists throughout the study were as follows: Active-Friendliness (A-I), Passive-Friendliness (A-II), Matter-of-Fact (A-III), and Firmness (A-IV). Essentially, these attitudes were based on the Menninger Foundation standards.[3] Briefly, the attitudes could be described as follows:

A-I. The therapist takes the initiative without waiting for the patient to make overtures. The amount of interest and of affection is to be controlled and determined by the particular needs of the patient. Active friendliness may be expressed by solicitousness, extra attention, reassurance, praise for acceptable behavior or achievement, and companionship.

A-II. The therapist is always available and maintains contact with the patient, but does not force attention on the patient at any time. However he does explain all requests courteously. The patient takes the initiative and the therapist responds with feeling. Acceptance includes tacit approval of any and all behavior and language not interfering with what the patient is doing unless he is creating danger for others.

A-III. The therapist attempts to make no emotional response to the patient's pleas or agitation except listening. No concern is to be expressed by the therapist, nor is reassurance to be given. Bids for sympathy are to be ignored. Neither friendliness nor firmness is to be presented to the patient.

A-IV. The therapist acts with definiteness and positiveness when making requests. The patient is not asked but is told. If a request needs to be refused, the therapist leaves no room for doubt or argument. Firm re-

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striction of aggression may occasionally be necessary by sharply calling attention to unacceptable behavior, or by isolating the patient.

Distribution of Patients by Diagnoses and Attitude Conditions

	*Diagnoses**			
Attitudes	*P.S.*	*S.*	*C.B.S.*	*Total*
A-I	9	7	10	26
A-II	6	13	8	27
A-III	9	11	7	27
A-IV	8	10	9	27
Total	32	41	34	107

*Paranoid Schizophrenic (P.S.), Schizophrenic (S.), and Chronic Brain Syndrome (C.B.S.)

TABLE 1

All patients were evaluated by the MACC scale[4] on factors of *motility, affect, cooperation, communication,* and *total adjustment* before the beginning of the experimental treatment period and two months after the controlled application of the above attitudes. All patients participated in occupational therapy five days per week, one hour daily. According to Ellsworth,[5] the following behavioral characteristics are measured under each behavioral factor. *Motility* represents increased motor activity, restlessness and agitation. *Affect* measures the degree to which a patient is pleasant in dealing with other people. *Cooperation* determines the ease of manageability in performing what a patient is asked to do. *Communication* tests the ability to engage in sensible conversation in appropriate contact with reality. The *total adjustment* score is achieved by combining *affect, cooperation* and *communication* scores, and measures the degree to which a patient is generally adjusted to a hospital situation.

These evaluations on the MACC scale were made by an independent occupational therapist as observer. In addition, progress notes written by the therapists in each clinic were evaluated by an independent judge (occupational therapist) with a three point technique by assigning weights for adjustment of 2-poor, 4-fair, and 8-good. This method of rating OT progress notes was used previously and was shown to be highly effective in predicting trial visit success in neuropsychiatric patients.[6] The analysis of the data consisted of measuring changes in patients' general conditions. It should be noted that these changes were not independent of other treatment programs. These changes were represented by four behavioral factors in relation to each attitude applied and were related to the three diagnostic categories. Due to discharge, trial visit and unavoidable changes in treatment program, 34 patients were dropped from the study before its completion. The breakdown of patients into three diagnostic categories and four attitudes is represented in Table 1.

RESULTS

The measures obtained were on behavioral changes in *motility, affect, communication, cooperation,* and *total adjustment* as well as on the changes in evalutation represented by progress notes recorded before and after the experimental attitude period. The McNemar test for significance of changes[7] was used for both the behavioral and the progress note evaluation. This test is especially useful in testing the effectiveness of a particular treatment (in this case, attitudes) on behavioral changes in a group of neuropsychiatric patients. Significant changes on functions of attitudes in each diagnostic category are represented in Table 2. The

Summary of Behavioral Changes Under Experimental Attitudes

Behavior	*A-I*			*A-II*		
Factors	*P.S.*	*S.*	*C.B.S.*	*P.S.*	*S.*	*C.B.S*
Motility	0	0	0	0	0	0
Affect	+**	0	0	0	0	0
Communication	+*	0	+*	+**	0	+**
Cooperation	+***	+*	+*	0	+***	+*
Total Adjustment	+*	0	0	0	0	0
	A-III			*A-IV*		
	P.S.	*S.*	*C.B.S.*	*P.S.*	*S.*	*C.B.S.*
Motility	0	0	0	—**	0	0
Affect	0	0	0	0	0	+*
Communication	0	0	+**	—***	0	+*
Cooperation	—**	+*	+**	—***	+*	+**
Total Adjustment	0	0	0	—*	0	+*

The symbols represent positive change (+), negative change (—), and no change (0), for Paranoid Schizophrenic (P.S.), Schizophrenic (S.), and Chronic Brain Syndrome (C.B.S.) patients.

*p < .05
**p < .01
***p < .001

TABLE 2

analysis of *active-friendliness* revealed that paranoid schizophrenics significantly improved in all factors, *affect, communication, cooperation,* and *total adjustment* with the exception of *motility;* the schizophrenic patients showed improvement only in *cooperation,* while the organic patients significantly improved only in *cooperation.* The analysis of data resulting from the application of the *passive-friendliness* attitude revealed significant improvement only in *communication* with paranoid shizophrenics. Improvement was found in schizophrenics in *cooperation* and significantly positive changes of behavior were detected in organics on *cooperation* and *communication.* The therapeutic practice of *matter-of-fact* attitude revealed significantly negative effects in *cooperation* with paranoid schizophrenics, whereas improvement resulted in *cooperation* with schizophrenics and significant positive effect in *cooperation* and *communication* in organic patients. The *firmness* attitude revealed mostly negative after-effects. Significantly negative effects were found in

motility, cooperation, communication and *total adjustment* in paranoid schizophrenics. With schizophrenics, however, only *cooperation* significantly improved. Positive effects were found in *affect, communication, cooperation* and *total adjustment* in organic patients. *Motility* was inhibited in paranoid schizophrenics with the attitude of *firmness.* Other than that, neither the attitudes nor the diagnoses revealed any significant relationship to changes in *motility.*

The means and the standard deviations of scores on the initial evaluation are represented in Table 3. It was indicated (a series of *t* tests were performed) that there were no significant

Means and Standard Deviations of Behavior Scores of Diagnoses

		*Behavior Factors**				
Diagnoses		*M*	*A*	*Coop.*	*Comm.*	*T.A.*
P.S.	Mean	5.96	12.36	13.64	12.84	38.85
	S.D.	2.24	2.78	5.19	1.18	10.86
S.	Mean	5.32	11.76	14.05	8.62	34.43
	S.D.	1.97	1.93	5.86	2.31	9.28
C.B.S.	Mean	4.89	13.07	13.92	13.73	40.72
	S.D.	2.73	2.36	4.07	2.67	10.12

*Motility (M), Affect (A), Cooperation (Coop.), Communication (Comm.), and Total Adjustment (T.A.)

TABLE 3

differences between the diagnostic groups on the behavioral factors with the following exception: Both the paranoid schizophrenics (t=8.84, $p < .001$) and the C.B.S. patients (t=7.30, $p < .001$) scored significantly higher than schizophrenics on *communication.* The C.B.S. patients were significantly higher than schizophrenics on *total adjustment* (t=2.16, $p < .05$). This finding indicated then that the three patient groups were essentially comparable on the initial evaluation. Also it suggests that the MACC scale does not differentiate patients by diagnosis, but assesses, rather, behaviors which are not peculiar to any particular diagnostic syndrome. However, the indication is that schizophrenics, as measured by MACC scale, are less communicative. This would be expected, due to their difficulties in interpersonal situations. The mean scores on *total adjustment* and their respective changes over the treatment period are graphically presented in Figure 1. These changes represent general trends in behavior excluding the *motility* factor, which is not included in the score of *total adjustment.*

Similar analysis for changes was performed on the progress notes, consisting of two independent evaluations, pre- and post- treatment. The analysis reveals significant improvement ($p < .01$) of patients assigned to A-1 attitude (*active-friendliness*). There were no significant changes with the other three attitude conditions.

Since no assumption of statistical normality, in the distribution of the variables concerned,

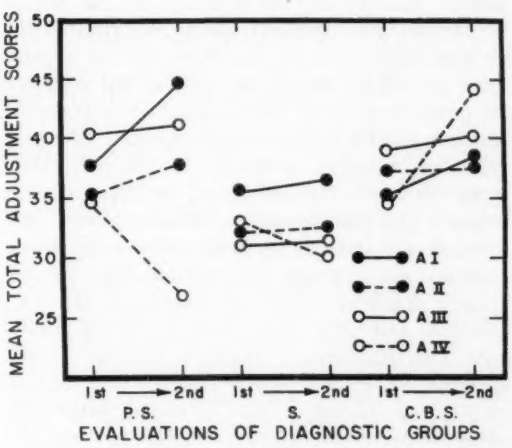

Figure 1

1. *Changes in Total Adjustment for Paranoid Schizophrenic (P.S.), Schizophrenic (S.), and Chronic Brain Syndrome (C.B.S.) patients on Active-Friendliness (A-1), Passive-Friendliness (A-11), Matter of Fact (A-111), and Firmness (A-IV) attitudes.*

may be made, the contingency coefficient, C, was used to determine the relationship between progress notes and the changes on the five behavioral categories of the MACC scale. The number of patients improved on each of the five behavioral categories were correlated with the number of patients showing improvement, no improvement, or poorer adjustment as measured by progress notes. It was found that only improvement in *cooperation* significantly correlated with improvement on progress notes (C=.61, x^2 =21.20, 8 df $p < .01$). No significant relationship was found between the number of patients who showed more regressed behavior on any of the behavioral factors and changes as indicated by the therapists' progress notes.

DISCUSSION

In general, the findings indicated that paranoid schizophrenics' response to attitudes were more extreme than that of the other two diagnostic groups (Figure 1). It was found that significantly positive effects were produced by *active-friendliness* (A-1) in paranoid schizophrenics on all behavioral categories with the exception of *motility.* As often noted, this was to be expected since the paranoid group was not expected to show signs of mental deterioration to the same degree as other groups, and were more likely to profit from new experiences. The improvement with *active-friendliness* can be explained on the basis of paranoid pathology. This attitude minimized opportunity for misinterpretations of

others' behavior and the tendency for the patient to defend his position, which is characteristic of paranoids. It would be expected that a paranoid individual would be looking for evidence to prove that he is right, and to systematically attempt reinforcement of his position. Improvement in behavior, naturally, should have been expected where the attitude of the therapist was friendly and permissive, and did not provide any grounds for feelings of persecution or of being punished. In general, this attitude does not reinforce delusions which are easily set off with sensitive paranoids. This interpretation is consistent with significantly negative findings in the condition of *firmness,* where with the exception of *affect* (no change), all measured behavioral manifestations significantly deteriorated over the treatment period. Basically, as the attitudes progressed from *active-friendliness* to *firmness,* paranoids showed progressive deterioration on all behavioral factors.

No attempt was made to classify the schizophrenics into the traditional reaction types of catatonic, hebephrenic, and simple, since it is often noted that schizophrenics may vary widely among themselves both as to symptomatology and general picture. Thus it is extremely difficult to pigeonhole these patients, and they were grouped into generalized schizophrenic category for the purpose of analysis. Since it is such a heterogeneous group, and is very unpredictable in its behavior, it was difficult to form any specific hypotheses with the schizophrenic group in regard to the predicted behavioral changes. The only significant finding for the schizophrenics was that they all improved in *cooperation* under all of the attitude conditions. Thus this improvement must have been a function of therapy over the period of two months since it was independent of experimental attitude conditions. As would be expected, it is noteworthy that no change in *affect* was demonstrated during the experimental period with schizophrenic patients. They remained withdrawn, their *affect* remained flat, and they did not improve their capacity to communicate with others, as is typical of schizophrenics in general.

The most general symptoms of brain damaged individuals are disturbances in the visual-motor spheres, perseveration, memory defects and inability to learn new skills. Consequently they have difficulty in dealing with more abstract and indefinite situations. The result revealed that they became significantly more communicative and cooperative both under the *active-friendliness* and *passive-friendliness* attitudes as well as in the *matter-of-fact* attitude, which was in contrast with the findings on paranoid schizophrenics. It is interesting that the C.B.S. patients also improved on the *affect, communication* and *cooperation-with-firmness.* As often found, this attitude which involves structured positive approach, with very little ambiguity, is most effective with organic patients. It is likely that they seek more reassurance, and are able to continue effective communication and cooperation with the therapist when the situation is more structured and defined (A-IV). This would be expected of organic individuals who feel need for reassurance and who function more effectively in a well structured environment where no doubt is left as to their role in an interpersonal, working situation.

The analysis of pre- and post-treatment progress notes revealed that the over-all patient population did not significantly improve on any one of the attitude conditions. However, the judged improvement on the progress notes significantly and positively correlated with the over-all improvement only on the *cooperation* factor in the over-all patient sample. This finding clearly indicates that the emphasis in evaluation of a patient in a progress note is based chiefly on patients' ability to cooperate with the therapist. This suggests, perhaps, that the system of progress note evaluation neglects other behavioral factors, such as *motility, affect,* and *communication.* It is quite plausible that the occupational therapists may bias their progress evaluation with predominant concern with *cooperation.* Whether the progress note system is inadequate for evaluation of neuropsychiatric patients in occupational therapy, or whether it is directed purely at assessment of *cooperation,* is difficult to determine with the present data. This question remains to be answered. It may very well be that such behavioral factors as *affect, motility, communication,* and *general adjustment* are more subtle than *cooperation,* which is possibly more salient and outstanding to a therapist in influencing his evaluation of patients' progress.

The over-all analysis of each diagnostic category grouped into four attitude categories showed no significant changes as assessed by the progress notes. This finding may either be due to short duration of the treatment period (two months) or to therapists' difficulty in detecting changes which may be more apparent to an objective rater who is not in daily contact with the patient, while slow changes are taking place. On the other hand, the findings point out a need for more emphasis and awareness of other factors accompanying therapeutic relationship other than *cooperation.*

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THE OCCUPATIONAL THERAPIST'S ROLE WITH MENTALLY RETARDED CHILDREN

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In the last ten years, there has been much interest centered around mental retardation. The public schools have had provisions for some mentally retarded youngsters since the beginning of the twentieth century. However, prior to 1950, little was done with other groups of retardates like the trainable or dependent retarded, other than to care for them in residential facilities, where for the most part they would be forgotten.

A few factors contributing to a change in services for mentally retarded youngsters have been the rapid advances of medical science, which has decreased the mortality rate; a reappraisal of the purposes of our residential institutions due in part to rising costs and the numbers of other individuals in need of such care; the emphasis placed on utilizing all our manpower effectively and efficiently; and the tremendous impetus of well-organized parent groups. These, along with may other reasons, have led toward the growing trend of planning and caring for these children in their own communities.

Mental retardation is not a disease. It describes a condition. It is a term used to describe a youngster who is slow in developing mentally. It tells nothing about the extent of the condition, etiology or prognosis.

Mentally retarded children are often classified into three levels according to the degree of their mental development. Through the years, much has been learned about how children in the various levels function.

The educable mentally retarded child. This is a child who cannot profit from regular academic training. Perhaps by the time he is sixteen years old, he may learn certain academic skills in a special class on a second, third or fourth grade achievement level. He may learn to become self-supporting as an adult in unskilled and semi-skilled jobs and can learn to get along in society. Speech and physical development may be adequate. Mental development is one-half to three-quarters the rate of an average child. Children at this level will normally have an intelligence quotient ranging from 50 to 75 with reasonable deviations.

In the past, public schools have made provisions for children at this level. In the last decade improved programs have been instigated by various community agencies for the educable mentally retarded child.

The trainable or dependent mentally retarded child. The trainable mentally retarded child cannot learn academic school work. He can be trained to learn simple words or numbers by rote. Self-care skills, social relationships, and how to become useful in the home or sheltered environment with supervision can be learned. Speech and physical development may be limited. Mental development is one-quarter to one-half the rate of an average individual. Children at this level will normally have an intelligence quotient ranging from 30 to 50 with reasonable deviations. Supervision will be needed throughout their lives. Although the trend today is to provide for the trainable mentally retarded child in the local community for as long as possible, eventual placement may be in an institution.

Many public school systems have added and are adding classrooms for youngsters at this level. We therapists will be seeing more of these children since they are beginning to be provided for in the community.

The totally dependent or custodial mentally retarded child. This is a child who cannot be trained even to care for his bodily needs. He needs complete supervision throughout his life and cannot survive without it. Intelligence quotient is usually below 30.

A LOOK AT OT

Perhaps the first duty occupational therapists have toward mentally retarded children is to rid themselves of their prejudices. Feelings toward retardates in relation to treatment objectives should be examined. The retarded can be helped. Many will live useful and productive lives. Attitudes toward the retarded have a great deal to do with their success or failure. They should not be considered hopeless. These youngsters may not progress rapidly, but they can progress at least to their capacity if properly helped.

Whether training retarded youngsters can be considered therapy is probably a semantic consideration. If these youngsters do not receive training, they will indeed be handicapped. Not be-

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ing able to participate in society due to a paucity of adequate training is perhaps the cruelest reason for any disability. The occupational therapist, equipped with knowledge in those very areas the retardate lacks but can acquire with training, is definitely justified in working with mentally retarded youngsters. Occupational therapists have the responsibility of giving them the advantages of their services.

Working with children directly in the treatment center or guiding their parents or teachers in the home, classroom or sheltered environment is the way the occupational therapist can serve these youngsters.

All self-help skills of feeding, dressing, toileting, washing and grooming must be taught to many retarded youngsters, especially to the trainable retarded. Helping them to become more independent, to learn how to play, share, follow instructions, complete tasks, control behavior, consider others, ask for help, be courteous, and obey rules are some of the social skills which therapists can give aid in developing. The motor skills leading to walking, running, climbing, as well as learning how to coordinate those muscles necessary for manipulating the arms, hands and fingers adequately, are other areas in which the occupational therapist can foster development.

The skills employed in manipulating toys, for example, lead to turning a door knob or hooking a latch for retarded youngsters just as they do for our other patients. The knowledge the occupational therapist has, for instance, concerning fasteners on clothing may be of value to a teacher of trainable mentally retarded youngsters or to a parent.

The therapist should be aware of which agencies in the community work with retarded children and make himself available to them if asked to do so.

Therapists will begin to see more retarded youngsters in treatment centers. Two excellent sources on the practical approach to working with retardates are Kirk, Karnes, and Kirk's book, *You and Your Retarded Child*,[1] and Rosenzweig and Long's book, *Understanding and Teaching the Dependent Retarded Child*.[2] Both books contain excellent presentations on activities of daily living techniques. This is interesting when it is considered that occupational therapists and other rehabilitation workers, as we think of these persons in relation to ADL, had little if anything to do with the writing of these books. There are many other good sources.

Not only will the therapist find references on retardation helpful for retarded children, but they will be useful for other patients as well, since many of the sources contain occupational therapy principles.

All retarded youngsters will not benefit from training. Those who do will often progress slowly. Trying to classify children into particular levels, prognosticate or suggest institutionalization to parents is not within the occupational therapist's jurisdiction. To be sure, other team members may solicit our advice, but it is unwise to advise parents on such matters.

Placement in residential institutions is usually entirely a decision for the parents to make. They can be given the facts. These can then be weighed, and with adequate counsel the particular family involved can make an adequate decision regarding residential placement.

IN RETROSPECT

Retardation is within the occupational therapist's realm particularly with the trainable or dependent retarded youngster. More of these individuals are likely to be seen in the treatment center, public school, sheltered environment, and in the community. Occupational therapists need to be prepared for them. Retarded children have capabilities, although limited, that can be developed. They deserve skilled treatment just as other patients do. In fact, retarded children may have some of the same limitations. The occupational therapist does have a role with mentally retarded children.

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THE EVALUATION OF PSYCHIATRIC RECOVERY

The Social Adaptability Test

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The purpose of this paper is to suggest ways by which the physician, psychiatrist or any member of the therapeutic team can improve the evaluation of social integration of mental patients who have recovered from their emotional disorders. With this objective in mind, the basic question becomes: How can the aide, or therapist in the physical medicine and rehabilitation service evaluate the social adaptability of mental patients so as to facilitate their returning to the community and their family? This is to be done without prolonging their hospital stay unnecessarily or discharging them prematurely. This question has been the daily concern of the medical and paramedical personnel in our mental hospitals for some time. They would like to know when the illness has run its full course and when the patient has made a complete recovery or a social recovery and is ready to live outside the hospital in the community under supervision and guidance of responsible relatives or persons.

Mental health is measured by the individual's capacity for happiness. Social integration is the ability to establish effective interpersonal relationships. Poor contact with other human beings is an index of emotional illness. A person may have lost the ability to reach out to others, to use social opportunities or to enjoy life. Objective evidence of psychiatric symptoms, as for example in a phobia, is recorded in terms of the patient's facial expression, his body posture, voice, gait, movements, stance, speech pressure and mood. There may be however, no organic structural change involved and yet a systematized delusion may completely disable a person, as in true paranoia or schizophrenia, in his ability to function in a gainful occupation, in living with his family and living in the community. Emotions have a destroying power. This results in socially harmful consequences. We have to measure disability and ability in the social, emotional and interpersonal areas. This person is not happy, does not have a gratifying love life, is an unsatisfactory marital partner and friend and is never relaxed or comfortable. The integrating force of the personality, the human relations evaluations, and the solution of the problem of hostility are pertinent problems in evaluation of psychiatric disability and recovery from it.[1]

The personal and professional motivation for the physician and paramedical personnel to perform a more thorough appraisal of social integration is two-fold. In the first place, by specifying the particular limits of a patient's ability, the physician becomes instrumental in preventing possible future frustration and loss of hope by the patient, his family, community and employer when they fail to understand the patient's limitations correctly. Second, equally gratifying to the physician at the same time is his ability to indicate what he believes to be the safe upper ranges of the patient's capacities and thus point the way for the worker, his employer and others to utilize his abilities to better advantage both on and off his job. The modern trend, in addition to treatment of disease and disability, involves the process of both safeguarding and utilizing abilities, that is, rehabilitation of the total person. This should be done for each person whether he is a worker or housewife, young or old, an athlete or severely disabled person. For each, depending on his own unique balance of fitness and unfitness for human activity, the question remains the same: How can the person utilize his emotional abilities to get the most out of life without hurting himself or others?

Rating scales for evaluating mental patients are designed with the goal of diagnosis similar to the function of laboratory medicine. There is a lack of uniformtiy of use and application of these. There are scales for psychiatric aides and nurses,[2,3,4,5] and scales for trained clinicians.[6,7,8,9,10] They are used mainly for describing mental patients in an objective fashion in order to compare one patient with another. They are based on symptoms and defense mechanisms of mental patients. They are not based on the patient's rehabilitation or his restoration to the community. The language and terminology do not lend themselves to full utilization by the patient and his constellation. It is at best a trend analysis of a patient's behavior. They are used for describing the patient's behavior in the hospital, the severity of his symptoms, the degree of mental disturbance, the changes after treatment of various types, and as a test of the skill in observation of hospital personnel. They are based and described in terms of polarity, i.e., symptoms versus recovery, and rated from 1 to 4+. They use statistical methods and require

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a specialized training for their utilization and interpretation. Their complexity discourages their universal use by all personnel on the therapeutic team in a neuropsychiatric hospital.

The reason for the comparative lack of knowledge is that there have been no objective criteria for evaluating the social integration of the patient. This has been done by the medical and paramedical professional personnel by intuition, the rule of thumb techniques and varying experience. The modern trend in rehabilitation of mental patients has been to extend knowledge more and more into the objective techniques of evaluating psychiatric patients.[11,12]

The evaluation of social adaptability will be discussed. The intention is first to avoid the usual mistakes in evaluating ability. How easy it is for a misunderstanding to result in emotional and economic misfortune when the attending physician follows the practice of basing his evaluation on subjective classification systems. This will be discussed under *the rating method.*[13] The physician, unless he is careful, early becomes accustomed to using equally harmful negative approaches and bases his evaluation on disability instead of ability as pointed out in the section known as the *disability method.*[13] It is easy to avoid the pitfalls of the rating and disability methods by means of a positive, individual, specific approach known as the *specific method.*[13] This is based on objective terms which point the way for the person to utilize his abilities in attaining a more rewarding life of emotionally satisfying activity. To sum it up, one must accentuate the positive, eliminate or minimize the negative, and not use the in-between in rating the social adapability of our fellow men.

In the *rating method*[13] adjectives and adverbs are used to describe the degree of a person's ability for social or physical activity. Adverbs and adjectives are unique in that they always are a part of a comparative scale, or group of words, such as: good, better, or best; little, moderate, or great; and occasionally, frequently, or constantly. One fallacy of using rating scales is that these evaluations will reflect individual characteristics of the person doing the rating. This results in a misunderstanding and does not give a complete profile, because the evaluations are either positive or negative, dependent on the phrasing of "no" or use of *only* in describing the characteristics which are rated. The use of the numbers 1, 2, 3, 4, or letters of the alphabet a, b, c, d, with definitions is also fraught with difficulties because of the implications and lack of clear definition as applied to the situation with its varying shading of black and white; i.e., positive or negative.

The theory of the *disability method*[13] is that persons are to be classified into medical groups according to their disabilities. Then if one had a list of positions for each of these disabilities all one would have to do is match the handicap with the job and place the person. The fallacies that have resulted from this are two-fold: the assumption that all persons with the same disability also are alike in their abilities. This fails to take into consideration the great importance of human variations found in each person. The fallacy may be stated: the abilities of 100 men who are blue eyed are alike, or six feet tall are alike. The second fallacy of this method is that when one thinks in terms of groups, the next step is to think in terms of "average." What can the average person with a specific disability do? This results in the error of categorizing this disabled person without really evaluating and utilizing all the rehabilitative potentials which are present in this individual. Also in using this method one defeats the purpose of rehabilitation by spotlighting the diagnosis with its categorical labeling as to prognosis, and negative aspects of the patient's performance as interpreted by the layman. This sociologically certifies the inferiority of the disabled and segregates society into the disabled and the healthy, intact human being.

The *specific method* of evaluating physical abilities has been developed in the last 15 years for objective evaluation of physical fitness.[13,14,15] Careful studies have revealed that ninety-nine percent of healthy human beings possess some degree of limitation of physical activities in relation to their abilities. The specific questions which are answered are: Physically fit for what? What activities can this person perform and how much? Realistically there is the need for evaluation of the total physical and emotional assets of the whole person for activities around the clock for the duties of daily living as well as working. How can a person utilize his physical abilities to get the most out of life without hurting himself? The purpose of this method is to evaluate and utilize the patient's ability in contrast to treating disease and disability. This aspect of preventive medicine is the responsibility of every practicing physician. This results in the satisfaction of being able to help the patient protect his weaknesses, utilize his strengths, and avoid the pitfalls of the disability method. Personal abilities are accentuated without errors of thinking of disabled groups and of the average in performance.

The principle of the *specific evaluation* uses the objective units of expression instead of the subjective methods of expression which plague the other methods. The principal objective unit is the hour. This is utilized with other specific units such as the pound, the safe maximum degree of ability which the person possesses for a series of standard activities; for example, the ability to lift

EVALUATION OF SOCIAL ADAPTABILITY

Page 1

NAME	A. L.
REG. NO	—
WARD NO.	7
CLINIC	PRINT (MAT)
DAYS OF WEEK IN CLINIC	5
HOURS PER WEEK	15
DATES OF STARTING	

SPEECH	HOURS PER WEEK DATE 3-7-60	DATE 3-7-60
Normal Intensity	15	15
Understandable	15	15
Applicable to situation	15	15
Connected in logical sequence	15	15
Communicates needs	15	15
Asks for help in task	15	15
Can answer questions	5	5
Can respond to others	15	15
Socially acceptable	15	15
Gives information	15	15

Page 2

SPEECH (cont)	HOURS PER WEEK DATE 3-8-60	DATE 3-7-60
Reports observations	15	15
Favorable regard of self	15	15
Desires to leave hospital	15	15
Would leave if had a job	14	14
Intense	10	10
Very loud		
Repetitions		
Are barely audible		
Talks to self		
Swears		
Teases others		
Irritable	5	5
Ideas of reference		
Ideas of persecution		
Anticipates disasters		
Indecisive		
Perplexed		
Fearful		
Preoccupied with illness		
Inferior self regard	1	1
Grandiose self regard, unacceptable socially		

Page 3

BEHAVIOR	HOURS PER WEEK DATE 3-8-60	DATE 3-7-60
Likes to be with others	15	15
Relates well to others	15	15
Cooperative with others	15	15
Aware of roles in setting	15	15
Recognizes if annoying others	15	15
Reacts in appropriate fashion to others	15	15
Shows interest and enthusiasm	15	15
Takes criticism in friendly fashion	15	15
Tryn to do what is expected	15	15
Obeys instructions	15	15
Is safety conscious	13	13
Takes pride in activities	15	15
Confident about abilities	15	15
Original and creative	12	12
Able to assume responsibility	15	15
Punctual in activities	10	10
Participates in group as leader	15	15
Participates in group as active participant	15	15
Capable of tolerating competition	15	15
Socially acceptable behavior	15	15
Inappropriate gestures		
Inappropriate grimaces		

Figure 1

EVAI UATION OF SOCIAL ADAPTABILITY

Page 4

BEHAVIOR (cont)	HOURS PER WEEK DATE 3-8-60	DATE 3-7-60
Manneristic movements		
Bizarre postures		
Restlessness	5	5
Broad changes in mood		
Apathetic constantly		
Euphoric constantly		
Depressed constantly		
Disoriented		
Sitting unoccupied		
Socially unacceptable behavior		
PERSONAL APPEARANCE & HYGIENE		
Decorum in choice of clothing	15	15
Ability to dress self well	15	15
Maintains clothing, clean and repaired	15	15
Uses clothing in accord with weather and task	10	10
Able to groom self well	15	15
Proper toilet functions	15	15
Social awareness	15	15

Page 5

PERSONAL APPEARANCE & HYGIENE (cont)	HOURS PER WEEK DATE	DATE
Bizarre choice of clothing		
Resistive to dressing		
Untidy in clothing care		
Unaware of weather and task in choice of clothing		
Unaware of self grooming		
Untidy in toilet function		
Social unawareness		

THERAPIST OR AIDE C. B. (MAT)

SUMMARY:

Patient's behavior is hyperactive. Frequently patient must be slowed down through use of activities involving use of bodily muscles. At times, reference is made to mistreatment by stepfather. Extreme interest in securing employment is expressed. Patient is likeable and is able to integrate self with care in clinic. He is easily offended by references to ethnic group to which he belongs (Spanish American).

Figure 2

up to twenty-five pounds intermittently for a total of an hour per day as in *Profile of Physical Ability.*[13] It is clear that this test does not express absolute facts, the physician is merely using pounds and hours as an objective means of expressing an opinion.

As a result of this, with the use of the hour as a unit that begins with zero and extends to hours around the clock covering the period of observation, the therapist is afforded a comfortable flexibility of opinion in setting the limits of a person's capacities and yet is able to express his judgment in a specific manner rather than in general terms. With this objective scale of reference to help state his opinion, he can be just as generous or conservative with his use of the hour as he sees fit and at the same time avoid the generalities that often lead others astray.

An attempt is made to do this quantitatively and qualitatively by designing the Social Adaptability Test (Fig. 1 and 2). This test has 56 items, in the three broad categories of (1) *Speech,* (2) *Behavior,* and (3) *Personal Appearance and Hygiene.* It is designed for used by the physical medicine and rehabilitation therapist to measure the recovery of the neuropsychiatric patient. All 56 factors are designated in hours-per-week and compared to the total hours-per-week in the therapy. Social adaptability, as used in this discussion, refers to the degree of a person's emotional tolerance for different physical activities and environmental hazards he may encounter personally, occupationally or socially. The basic objective should be consideration of the patient's abilities for activities around the clock—for the waking hours of the twenty-four hour day. This is predicted from the attendance in a clinic or activity in physical medicine and rehabilitation where he spends the major part of his time. A zero or blank indicates no social activity of this kind. An entry in the area of negative characteristics indicates the residual of disease or disability when the patient has achieved maximum recovery.

A profile is first made when the patient has been judged, by the therapist, to be fully recovered and repeated two weeks later as a check. In filling out the profile the therapist usually prepares two copies, one for the ward physician, and one for the physical medicine and rehabilitation service. The diagnosis does not appear anywhere on the form. The average time spent by the therapist is about 15 minutes. This saves the therapist the time spent in writing long descriptive progress notes.

This is then referred to the chief of the physical medicine and rehabilitation service at which time a medical rehabilitation board meeting is scheduled to discuss future plans for the patient's rehabilitation and possible discharge from the hospital. The various forms of discharge considered are: maximum hospital benefits, trial visit, member employee, foster home, day hospital, night hospital, and domicilliary care—dependent upon where he can live, and in what gainful occupation he can function.

All 56 factors have been tested by five therapists and evaluated for a total of ten patients. They have been found to be valid for all significant social activities one may encounter in any environment at any time.

SUMMARY AND CONCLUSIONS

The purpose of this paper has been to suggest methods, in keeping with the modern trend of rehabilitation among the medical and paramedical professions, to extend therapeutic goals from treating disease and disability to include procedures for utilizing abilities, and improve ways of medical evaluation of social adaptability. The need is for an evaluation of the emotional assets of the whole person for activities-around-the-clock as well as for duties of daily living. Regardless of the diagnosis or status in life, the basic question remains the same for each person. How can each person utilize his emotional assets to get the most out of life without hurting himself?

The dangers of using the *rating method* with its prohibitions of *no* or *limited* or *light engagement in activities* results in misunderstandings which result in economic and social misfortune to the individual. Equally harmful is the *disability method* in which evaluation is based on disability instead of abiltiy pertaining to disease of the individual. The *specific method* (The Social Adaptability Test) has been devised to avoid these pitfalls. It is positive, individual and specific for the person's abilities. In the *specific method* an objective unit, the hour, is used to express the duration of the activity evaluated as compared to the total period under observation and treatment in the physical medicine and rehabilitation clinics.

This is an objective means of expressing an opinion, not an absolute fact. An opinion so expressed can be readily understood by others thus preventing the serious misunderstanding that often results from the use of subjective terms. The *specific method,* moreover, permits the evaluation of each person's abilities on a strictly individual basis and thus avoids the danger of evaluations based on favored, average persons in the respective disability groups, as in the *disability method.* The positive individual qualifications of the person at hand are always emphasized, not the negative characteristics of groups or persons. In the evaluation, only the degree of emotional fitness for human activities and hazards is important, not the diagnosis. The specific questions to ask about the person at hand should be: Socially fit for what?

(*Continued on Page* 82)

CHORAL READING AS AN ACTIVITY

EVELYN JANE DRESSLER POWELL, O.T.R.

Choral reading can be an activity of major importance in a recreation program for the handicapped. At the Tulsa Recreation Center for the Physically Limited in Tulsa, Oklahoma, choral reading is in its second year and is one of the most popular activities in their expanding program.

Two years ago the occupational therapist from Hillcrest Medical Center across the street acted as a volunteer at the recreation center during some of her lunch hours to prove that handicapped persons would prefer the best and most beautiful experiences possible. A group was developed for these choral reading periods. About half of the participants were blind and the others were struggling with athetosis or other severe problems. A few had serious speech limitations.

At the first meeting, repeating phrase by phrase after the leader, they went through a psalm, part of Vachel Lindsay's "General Booth Enters into Heaven," Carl Sandburg's "Fog," and several short inspirational poems. Enthusiasm was immediate.

Not one of the first group had ever performed these fine things. To be saying great words and hearing the beauty of their own voices in unison was a new experience.

At the second meeting they went through the tongue-twisting humorous poem of Ogden Nash, "Bankers Are Like Everyone Else Only Richer." Experiments with voice grouping — women together, men together, a solo voice followed by the whole group coming in strongly — were tried, and much of their timidity began to disappear, as they realized the possibilities within themselves as group members.

After several meetings, the blind members asked for help in preparing a poem to give at the next meeting of the local society for the blind. Also a performance was given at the next monthly party of the recreation center.

Soon thereafter the occupational therapist had to stop her volunteer work because of schedule conflicts, but a very competent and enthusiastic sponsoring volunteer took over. The program has grown in individual pleasure for the performing members, and has become a source of pride to the recreation center and its sponsors.

This choral reading group has now performed several times in public, has made a TV appearance, has acquired handsome robes for effective staging, and provides the nucleus of talent for the center's latest activity — a radio workshop in which members will learn how to make sound effects and experiment with their abilities in radio acting.

"Do what you please, but see to it that he keeps his mind off himself."

NATIONALLY SPEAKING

Accreditation of Occupational Therapy Departments

At the last meeting of the student affiliation committee, I was asked to give you more detailed information on the project entitled "Evaluation of Clinical Practice Centers." I was requested to emphasize the specific objectives of the original committee appointed to develop methods and procedures for this project and to clarify the reasons why the project was undertaken. In other words, what needs were going to be met or what problems were going to be solved by the evaluation?

In preparing this account, I have turned for accuracy and historical perspective to the records of the AOTA and shall quote freely from various reports published in OT&R and AJOT.

It is interesting and significant that the first reference to the need for rating occupational therapy departments came from the field through the House of Delegates and not from one of the education committees. The minutes of the House of Delegates meeting held in New York City in October, 1942, contain the following recommendation which was referred to the Board of Management: "It is recommended that there be some plan made for rating and classifying occupational therapy departments; that this plan be made in consultation with some, or all, of the following organizations, depending on the type of hospital: (a) the American Medical Association; (b) the American College of Surgeons; (c) the American Psychiatric Association; (d) the National Tuberculosis Association; (e) the American Hospital Association." (OT&R, Vol. 22, No. 1, Page 51.)

The next reference occurs in the report of the educational field secretary covering the period April 1 to September 30, 1944, where Miss Fish made the following statement: "Clinical inspection, advising and even accrediting of hospital occupational therapy departments. This should take the form of periodical inspections. The field secretary should serve as an official inspector, accompanied in each instance by one or two therapists who are specialists in the particular medical program under surveillance. *There is too great a variance of practice and program in departments which indicates a need for standardizing procedure.* Factors to be judged should include type of patients, services offered, methods of referral and prescriptions, library and case record facilities, lectures available, living quarters and maintenance, related services and departmental and interdepartmental relationships. The program would serve to: (a) broaden and strengthen occupational therapy programs in general. (b) enable new schools to set up adequate clinical training, (c) eliminate others (i.e. centers) not having offered an adequate standard of work." (0T&R, Vol. 24, No. 1, Page 53.)

Continuing interest in the need for certification of ocupational therapy clinical training centers was indicated by the statement that this topic was discussed at the meeting of the Board of Management on May 10, 1946, (OT&R, Vol. 25, No. 3, Page 80.) During the same period the subcommittee on student training was working on formulating the essentials of a clinical training program, which the educational field secretary, Miss Hurt, stated in her report to the Board on March 17, 1947, would ultimately provide a basis for accrediting of clinical training departments (AJOT, Vol. 1, No. 2, Page 108-109.)

During the period September 1, 1946, to July 1, 1947, the educational research program under the guidance of Dr. Hyman Brandt started. Miss Hurt, the educational field secretary, stated in her report covering this period: "Any program of education must have a dual approach, (1) development and (2) evaluation.. They are inseparable and continuous. Any program which concerns itself with occupational therapy education must consider its dual aspects: (1) the school program, and (2) the clinical training program. These also are inseparable—two parts of a whole.

"Therefore the educational research program being carried on by our profession and channeled through the education office, is concerned with the development and evaluation of the school program and with the development and the evaluation of the clinical training program." Miss Hurt then listed various projects which had been started to develop and evaluate the schools and clinical centers. For the schools she mentioned:

Development Phase

The curriculum guide and schools survey.

For clinical training centers: formulation of essentials of a clinical training program as a basis for further development and accrediting of centers.

Evaluation Phase

Construction and administration of examination for registration and related correlation studies.

Development of uniform report blanks for reporting student proficiency.

Development of uniform method of handling all reports.

Preliminary work on development of a raters key for uniformity in using student report form.

It is pertinent to note that all of the items listed under both development and evaluation phases for clinical training centers were the direct result of work done by special committees of the subcommittee on clinical training and involved no or minimal use of educational research funds.

In the report of the education office for the period 1947-1948 the following statement appears: "Projects which have *not yet been approached* by the education office, beyond the preliminary talking stage, but which are included in the plan for the three-year educational research program and on which work has been started by various committees are:

"1. Establishment of procedures for the accreditation of occupational therapy departments." (AJOT, Vol. 2, No. 5, Page 309.)

At the midyear meeting of the subcommittee on clinical training held in St. Louis in March, 1948, a special committee was appointed to study various plans used by other organizations to evaluate their field or clinical programs; and to formulate methods for accrediting occupational therapy clinical training centers. The minutes of this meeting state, "Accreditation was the big issue of the meeting." The charge to the special committee included the following:

1. It was the general feeling that more than a rubber stamp approval should be given.

2. Suggestions relating to possible methods of evaluation were listed as:
   (a) self-evaluation
   (b) evaluation by local or state committees
   (c) evaluation on the basis of that used by secondary schools

3. Standards and scale on which to evaluate were listed as:
   Administration
   Plant
   Training program
   Treatment program

The committee was further instructed to investigate procedures and forms used in allied medical groups such as the American Dietetic Association, the American College of Surgeons, the nursing associations and educational efforts such as the Co-operative Study of Secondary School Standards.

This special committee of the subcommittee on clinical training was one of the committees referred to in the field secretary's report for 1947-48, as cited above.

During the period from March, 1948, to August, 1949, the committee studied various methods of evaluation and decided to devote its efforts to the development of self-evaluation procedures, to be supplemented by inspection visits by an accreditation team. In the minutes of the August, 1949, conference the following statement appears: "The total program of accrediting occupational therapy departments assumes tremendous proportions. The *initial* stage of development of the program entails establishment of standards. The committee hopes to achieve a set of standards from the experimental stage of the first procedure of accrediting which is the *evaluation of an occupational therapy department.* An evaluation form has been completed and is to go to 50 clinical training centers. An analysis of the results of this preliminary survey will be studied to establish validity of the form and set standards." In August, 1951, the committee reported as follows: "The purpose of the evaluation instrument is twofold:

"(1) To develop a means of evaluating occupational therapy departments and their clinical training programs, and of rating departments according to their standing. (2) To ascertain what are the actual standards which differentiate a good occupational therapy department from a poor one."

The special committee worked on this project from March, 1948, to October, 1955. During the period of committee activity a four-part form was developed, which was composed of the following elements:

Part I: The Institution
Part II: The Occupational Therapy Department
Part III: The Clinical Practice Program
Part IV: The Affiliating Student's Evaluation and the School's Evaluation

Parts I and II were complete with scoring keys. Part III needed revision and probable breakdown into areas. Part IV forms had been developed and were being evaluated in trial practice.

At the conference in 1955, the chairman reported that it was planned to request a grant to carry on the project as it was impossible to accomplish a task of this magnitude using only committee members who had other responsibilities and were further hampered by lack of time and as specialized technical skills and money where needed for the project. It should be noted that there was no provision for committee expenses, so that mimeographing, clerical time, travel expenses, etc., were all borne by the individual members. A grant proposal was prepared for the Kellogg Foundation to "Develop Criteria, Techniques and Procedures for the Evaluation of the Practice of Occupational Therapy in Student Affiliation Centers," but was never submitted.

In the introduction to this request the following statements appear: "There is no organized procedure for the evaluation of professional practice in occupational therapy departments, regardless of their use as student affiliation cen-

ters. The AOTA recognizes that the effectiveness of clinical function varies with the quality of procedures employed in occupational therapy departments throughout the country. It also realizes that only the best professional practices will insure maximum benefit to patients, as well as the ultimate in the preparation of student therapists. The Association feels that the development of procedures for the evaluation of occupational therapy departments would be one of the major steps toward advancing the profession's contribution to the public welfare . . . The proposed evaluation of the clinical function would furnish a sounder basis for the comprehensive revision of the essentials of the curriculum." The objectives of the project were stated as follows:

1. To ascertain the existing standards and procedures employed in the practice of occupational therapy in departments designated as student affiliation centers.

2. To determine the existing standards and procedures utilized in the student affiliation program of those departments.

3. To develop criteria for assessment of the quality of both professional practice and student affiliation programs in those departments.

4. To develop forms and procedures for the appraisal of occupational therapy practice and student affiliation programs as follows:

a. self-appraisal by occupational therapy department personnel

b. appraisal by the school utilizing the department as a student affiliation center

c. appraisal by the student upon completion of the affiliation

d. appraisal by duly authorized representatives of the national evaluation commission.

5. To develop a scoring system for evaluation of the quality of current practice in student affiliation centers. This system shall include the factors, and relative weighting of the factors, which differentiate among "good," "acceptable," and "poor" occupational therapy programs.

6. To establish the machinery for the administration and supervision of an evaluation commission which will be charged with the conduct of the evaluation program: visitation, appraisal, report, recognition or non-recognition, and follow-up.

7. To adapt the evaluation procedure for use in appraising all occupational therapy departments regardless of their utilization as student affiliation centers.

The grant request was never submitted because of pressures of other projects and there has been no further official action directed specifically toward this project.

This account provides the historical and chronological background on the accreditation project. It can be summarized as follows: In 1942 the House of Delegates recommended to the Board that rating procedures for occupational therapy departments be inaugurated. No specific action to implement this recommendation occurred until 1948, when a special committee of the subcommittee on clinical training was established to work on this assignment. This committee worked for seven years and developed a four-part instrument which was not adequate without further development in the committee's opinion, to accomplish its purpose. Therefore, the committee recommended that a grant be obtained to finance this essential project. A grant proposal was prepared but never submitted and no further official action has been taken to meet this expressed need from the clinical field.

In considering in retrospect the seven years of hard labor spent on this project, I know that at least three of the committee members have the following feelings:

1. Although the original request came from the field for rating of occupational therapy departments in general, the task had to be broken down into the smaller unit of initial evaluation of clinical training centers, since there was no way of enforcing standards, even when established, in hospitals and agencies which did not train students. There was a way of enforcement in clinical training departments—the schools could withdraw affiliation if standards were not met and maintained.

2. The method of preliminary self-evaluation was not really effective.

a. In spite of the committee's efforts to devise questionnaires that would elicit scorable material, the questions had to be so general that the answers had little meat or meaning.

b. Determination of treatment effectiveness could not be made on the basis of these general questions.

c. The variety of clinical situations was so great that no real pattern emerged which could be used as a yardstick against which to rate similar departments.

d. Many centers, although conscientiously trying to cooperate, obviously did not understand the meaning of the questions and therefore submitted completely inaccurate or inapplicable information.

e. A project which potentially had as much significance as "accreditation of practice" could not be adequately accomplished, even in its preliminary stage, by a self-evaluation procedure. Self-evaluation may be a good technique to achieve emotional acceptance of a rating procedure *after mechanics* have been worked out and the instrument is ready to use. It cannot be expected to produce workable basic information or valid standards of discrimination.

f. To be successful, the preliminary step in an evaluation procedure must be the development of a set of standards, a "yardstick" against which programs can be objectively measured. The development of this yardstick requires at least as much preliminary study and analysis as went into the development and maintenance of the registration examination.

As well as to give the background of the accreditation project, I have been asked to discuss specifically some of the problems which the therapists in the clinical area hoped would be solved by rating and accreditation. Some of these I have already recounted. Many other problems are implicit in the record although not specifically stated.

First, the clinical area was aware of and disturbed by the diversity of programs which were (and are) lumped under the title occupational therapy. These ranged all the way from excellent treatment-oriented programs to production units and simple diversional activity programs. There was similar diversity in the perception of staff requirements, from programs being directed and staffed by graduate occupational therapists to others which did not, and never had employed a qualified occupational therapist. All of these programs were called occupational therapy indiscriminately, so that the term had no definitive meaning. In some settings occupational therapy was a recognized part of the treatment program of the institution; in others it was simply a busy-work program carried on entirely outside the institution's concept of treatment. Physicians were, and are, confused by this lack of professional image and clear delineation of role and function. Other treatment services have requirements which must be met if the institution is to claim that the particular treatment is part of its service for patients. Clinical occupational therapists wanted similar requirements for the title and practice of occupational therapy.

The American Occupational Therapy Association saw the need for and provided mechanics to insure that all students in schools of occupational therapy were guaranteed a curriculum which would meet basic professional requirements by establishing the essentials of an approved school of occupational therapy and instituting an evaluation procedure through accreditation by the council of medical education of the American Medical Association. As early as the first decade of our professional organization, the need for and value of a formalized procedure certifying the qualifications of individual members was recognized, and implemented in 1932 in the form of a national register of qualified occupational therapists. The one area where definitive standards and procedures for enforcement were and are lacking is the area of practice. Clinical therapists wanted objective, established criteria against which their own programs could be evaluated, and which would provide documented, authoritative material to substantiate their efforts to improve existing facilities and practice for the benefit of their patients.

Directors and therapists in student affiliation centers wanted accreditation as a means of correcting perceived weaknesses or deficiencies in the clinical phase of the student's professional preparation. There were no *enforced* requirements in terms of treatment program, physical facilities, resources or staff necessary for the establishment and maintenance of clinical training centers. Theoretically, requirements are specified in Section IX of the *Essentials of an Approved School,* but in actuality they are a statement of desirable attributes rather than a condition of affiliation, since there is no consistent and effective pattern of inspection and enforcement. Students did not and do not have assurance that they will receive comparable programs in clinical experience in centers throughout the country.

1. There is no basic uniformity in the concept of function of occupational therapy in various centers within a disability area.

2. There is no control over the type or amount of supervision provided for students during affiliation. (Currently, in some centers students work under the direct supervision of registered occupational therapists, others under the nominal supervision of registered therapists, while in still others they are supervised and graded by therapy aides.)

3. There is no standardization in the content of material provided for students by different centers.

4. Factors which differentiate level and depth of clinical practice need to be identified and isolated so that departments can be rated against a uniform yardstick to determine their standing as "outstanding," "average" or "weak" programs.

5. After these rating procedures have been validated, they should be used to establish a roster of good clinical centers which can be used by any school desiring to establish clinical affilation programs.

6. These same rating procedures should be used to justify the discontinuation of clinical affiliation programs which are not functioning at an adequate level.

To recapitulate, the clinical area in general (that is both affiliated and non-affiliated departments) wanted: (1) Nationally accepted standards for clinical practice. (2) A rating procedure designed to determine whether or not these standards were being met in any specific department. (3) Machinery which would give the power of enforcement to the accreditation program.

Obviously the validity of establishing standards and developing methods of evaluation and accreditation of clinical practice centers, and ultimately of all occupational therapy departments, was recognized by both the Board of Management and the education office, but this project has never been given sufficient priority status to

be accomplished. It was included in the plans for the educational research program started in 1946; it was included in the plans reported in 1948; but somehow money to carry out this phase of the educational research project has never been available. Again it did not carry a high priority in the thinking and planning of the development advisory committee. There seems to have been intellectual acceptance of this project, but a strange reluctance to grapple with it on a reality basis. Admittedly it is a difficult problem to establish standards for clinical practice in a profession which serves so many different areas, in such a variety of settings; it is difficult to develop fair and objective discriminatory methods of evaluation and it takes courage and fortitude to enforce the established standards by withholding accreditation *wherever* this is indicated.

In this connection perhaps we should note that the project committee for recognition of OT assistants has essentially accomplished just this in the aide training courses in two disability areas. As a result the trainee on the nonprofessional level may enjoy what is not yet available to the occupational therapy student in the professional course, accredited clinical experience as well as didactic preparation.

It is interesting to speculate what the effects on our profession would be today if the requested procedure for accrediting of clinical practice and clinical affiliation centers had been given the priority it needed and had been carried through to successful implementation. Would we now, 42 years after our birth as a profession, be faced with the problem of role definition and delineation of function? Would we be plagued by the problems of our relationship with activity therapy? Would the multiplicity of "therapies" rampant in some of our institutions present the problems now current? If we had been prepared to supply the Joint Commission on Accreditation of Hospitals with specific guide lines for the evaluation of clinical programs in occupational therapy, could not this material now be a part of their publication, *Hospital Standardization Scoring Report?* If this material had been included would we now be concerned about our professional survival in some areas?

One can only salute the wisdom and foresight of the clinical therapists who in 1942 saw and expressed the value of accreditation of clinical practice centers to the profession.

— Naida Ackley, O.T.R.

Meeting of National Organizations Concerned With Rehabilitation

A meeting in December in New York City was sponsored by the National Rehabilitation Association and chaired by its executive director, Mr. E. B. Whitten. It was an informal sharing session centered around four topics: (1) the climate for rehabilitation legislation anticipated in 1961, (2) the recent regional workshops and hearings on the needs of handicapped children and adults, (3) the 1961 version of the Independent Living Bill and (4) legislative proposals for improving educational services for handicapped children.

Organizations represented, in addition to the National Rehabilitation Association and the American Occupational Therapy Association were:

National Association for Retarded Children
National Association for the Blind
National Society for the Prevention of Blindness
Goodwill Industries Rehabilitation Services
National Speech and Hearing Association
National Tuberculosis Association
American Heart Association
Council for Exceptional Children
National Society for Crippled Children and Adults
United Cerebral Palsy Association

The Consensus of the Group Discussions

It was felt that Governor Ribicoff would prove to be a good Secretary of Health, Education and Welfare. As Governor of Connecticut, he was a man who not only could be involved in the main issues of rehabilitation and could discuss them intelligently but he followed through with personal interest. It was also felt that he and President Kennedy would pretty well agree. Some significance was attached to the fact that Governor Ribicoff was the first cabinet member appointed and that he, himself, preferred this appointment to that of Attorney General.

As to reports of the study conducted by the subcommittee on special education under the chairmanship of Carl Elliott of Alabama:

Part I explains what the federal government provides for exceptional and handicapped children and adults.

Part II of the report will probably be the committee's recommendations. Funds for this study expired on December 31, 1960.

(See AJOT, XIV, 3, 1960, pp. 150-151 *Nationally Speaking*—From the President, and AJOT XIV, 4, 1960, pp. 230-231 *Letters to the Editor.*)

The representatives at the meeting felt that their support should be lent to any reasonable efforts toward rehabilitation programs, but caution should be observed in coordination on research and training, believing that a large central agency is not the answer to the problem.

HR13238, introduced by Mr. Barden — referred to as the Franklin Bill and also introduced into the Senate by Mr. Randolph — proposes to bring OVR and Special Units into one bureau. It also proposes to establish training programs for teachers and prospective teachers and provides for research. Direct grants would be available to states under this program. There seems to be little doubt that this bill will appear next year in one form or another. Legislation for rehabilitation and special education should originate in the House.

As far as occupational therapy is concerned the only grants available are those from OVR. Recruitment or public education would have to be a part of regular grants to schools for education as funds have never been specifically allotted by the federal government for recruitment and publicity.

Special education legislation for exceptional children includes cooperative research in the Office of Education, demonstration grant money, research in special education for the handicapped group, caption films for the deaf and blind, a fellowship program for retarded children and a juvenile delinquency program in the Children's Bureau.

Bills in the areas of blindness, deafness, speech and hearing deficiencies should provide for:

1. Scholarship and fellowship programs for the education of all exceptional children and grants to universities to be given to individuals, teachers, administrators and teacher educators.

2. In-service grants for expansion of facilities, personnel and for basic services in each state for the education of handicapped children. Extension and improvement grants to public and non-profit organizations; staff support grants, scholarships and summer workshops.

3. Research and education programs. There is specific need for research and demonstration grants in the Office of Education.

It was felt that each rehabilitation group's convictions should be spelled out and sent to Congress.

Changes which should be made in the Independent Living Bill:

Set up rehabilitation for persons who are not employable.

Expand comprehensive evaluation of the handicapped.

Offer federal grants for facilities and staffs of workshops.

Supplement gaps in Hill-Burton Bill.

Introduce a section to provide legal status for OVR and establish a position of director.

Amend the definition of rehabilitation (now specifies that the individual should be able to leave the institution or to relinquish care) so that an individual capable of making substantial gains through rehabilitation would be eligible.

Propose an amendment to P.L. 565 providing for financing on regional basis research, training and demonstration centers (possibly five years with a hope for permanent centers) to train doctors and others for the team approach concept.

Also discussed were the need for changes in the minimum wage law and its implications for sheltered work shops, the Internal Revenue Act which levies excise tax on transportation of agency personnel and the Interstate Commerce Regulation which prohibits an amputee from driving a vehicle in interstate commerce.

It was decided that another meeting of the rehabilitation groups should be held after the new Secretary of Health, Education and Welfare was in office and his policies were begun to be understood, possibly in February, March or April of 1961.

Respectfully submitted,
Virginia L. Caskey, O.T.R.,
Chairman Legislation and Civil Service Committee

QUERIES AND ANSWERS

The clinical procedures committee urges that you, the practicing therapist, use this column as a means of getting some help with your perplexing problems. Submit your questions to either Miss Miriam Scanlan, chairman, clinical procedures committee, National Jewish Hospital, Denver 6, Colorado, or to Miss Irene Hollis, O.T.R., editor, "Queries and Answers," field consultant in rehabilitation of the physically disabled, American Occupational Therapy Association, 250 West 57th Street, New York 19, N.Y.

We also invite you to express a difference of opinion to answers given or to supply us with additional information related to any of the subjects introduced here. Make this an organ through which the voice of the clinical therapist can be heard. The success of "Queries and Answers" depends upon your participation.

HANDEDNESS

Question: I would like information regarding the preferred method of treatment in dealing

with the handedness problem of a seven-year-old, female, cerebral palsied paraplegic child who is considered mentally retarded. Although she seems entirely ambidextrous for most activities and changes hands easily with no discernible ill effects, she is experiencing great difficulty in classroom activities such as printing and writing. When she changes from her right to her left hand, she begins forming her letters backwards and toward the left of the paper.

In this case, would it best to restrain the left arm regardless of history of family handedness or outcome of preference testing of the child? If so, should the restraint be used for all activities or just while she is writing? —E.M.

Answer: The description of the cerebral palsied child suggests that she has perceptual-motor disturbances. It is possible that her failure to develop hand dominance reflects inadequate development of functions of the parietal lobe.

If this evaluation is correct, then restraining an arm to develop dominance is a little like teaching a first grader long division. Too many developmental steps are being skipped. It would be preferable to make a complete evaluation of the child's perceptual-motor abilities, especially her body scheme and her ability to motor plan basic, gross patterns of motion. To evaluate body scheme use a modified version of MacDonald's[1] test. To evaluate ability to motor plan basic motion patterns, have her go through each of the motor steps of ontogenetic development, beginning with rolling over and emphasizing crawling in all three types of patterns (bunny-hop, side alternating with side, and crossed diagonal). If the child is not able to motor plan these activities easily and if you find her lacking in the concept of her own anatomical construction, it would be preferable to provide training of a far more basic nature than writing. Teach her the construction of her own body and how it moves. Combine teaching on an intellectual level with simple, gross activities requiring body visualization and planning. Utilize extra stimulation of cutaneous receptors and proprioceptors. Take the child through all the steps of ontogenetic motor development. When you reach the stage of relating self to outer space through such activities as ball throwing, emphasize recognition of directionality, especially from side to side. Work at a blackboard or on large sheets of paper might be helpful as an advanced, pre-writing motor training activity.

If, after treatment as outlined above, one hand does not emerge as dominant, then it would possibly be advisable for writing training to continue with use of the right hand only, regardless of history of family handedness. In a recent thorough review of data regarding laterality, Mayberry[2] suggested that establishment of right hand dominance was primarily a function of maturation. It would seem, then, desirable to facilitate maturation in an effort to establish dominance (and other functions) rather than to do so by establishing a habit of use.

— A. Jean Ayres, O.T.R.
Los Angeles, California

1. MacDonald, Joanne C. "An Investigation of Body Scheme in Adults with Cerebral Vascular Accidents," *American Journal of Occupational Therapy*, 15:75-79, (March-April, 1960).
2. Mayberry, Wanda L. *Laterality Functions and Their Implication for Occupational Therapy*. Unpublished master's thesis, department of occupational therapy, University of Southern California.

ARTHROGRYPOSIS

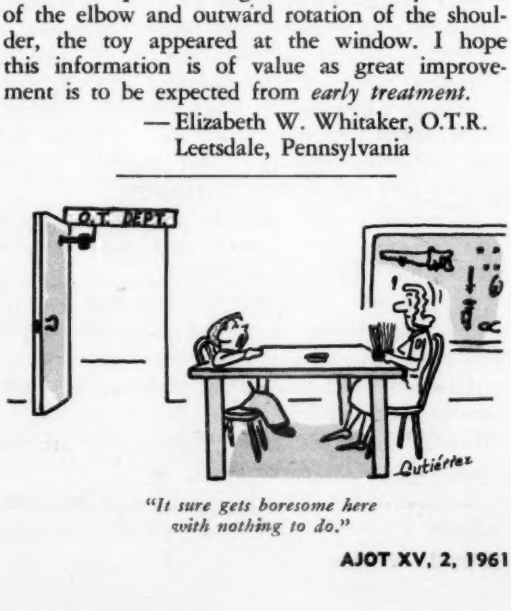
Question: Can you supply information as to how one should proceed with the treatment of a 19-month-old child with arthrogryposis?—L.C.

Answer: Little information is available on the subject of arthrogryposis except in pediatric journals. There remains disagreement as to whether the primary problem is nerve supply or malformation of muscle or joint. Therefore, treatment must be symptomatic with exercise in the direction away from that of deformity.

In clinical experiences, Dr. Jessie Wright has found that splinting has proven of great value. The arms are held in a similar position to a brachial palsy splint but with flexion of the elbow and supination gradually increased until full flexion and supination are attained.

In exercising the patient, the arms are retained at shoulder height and the elbows are not allowed to extend beyond right angle. Activity should encourage flexion of the elbow. A toy used successfully was made by putting a window near the top of a long box so that by flexion of the elbow and outward rotation of the shoulder, the toy appeared at the window. I hope this information is of value as great improvement is to be expected from *early treatment.*

— Elizabeth W. Whitaker, O.T.R.
Leetsdale, Pennsylvania



"It sure gets boresome here with nothing to do."

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Patient Projects . . .

(*Continued from Page 56*)

The motivation of the therapists was also stimulated by the requirement that they do some thinking and planning as to the most effective and beneficial way of encouraging the patients to complete the projects. The study activities were not of the "maintenance therapy" or "busy work" type that may be found in some clinics. As a result the therapists became better aware of their roles and their need to know more about group dynamics and the techniques of motivation.[7]

It appeared for justifiable reasons that in recent months the hospital had made no individualized efforts to motivate most of the patients included in the study. These patients were a challenge to the occupational therapists, who soon found they had to structure the study activities to a greater degree than is necessary for more active patients. As the results of this structuring seemed beneficial to the patients, this suggests to the authors that there are some regressed patients who will not respond unless a carefully structured therapy program is followed.

Finally, and of equal importance, the therapists were able to see some tangible results of their efforts. They learned that there were a definite number of responses to the packages that were sent home and which patients received them. This is in contrast to the usual and subtle patient changes which are difficult to measure. The effect of this and the other findings of the study contributed to the morale of the therapists.

SUMMARY

1. Thirty-four chronic NP patients, who had not been visited for at least one year and who received infrequent letters from relatives, made a series of gifts which were sent to an appropriate relative. Eighteen relatives responded in the form of letters, packages, or a visit. The response was considered significant enough to make the project a whorthwhile activity.

2. As a result of the study some patients seemed to gain group activity skills which we hope they will carry over into their daily activities.

3. Occupational therapists reported satisfaction with the study in terms of the establishing of new and more definite therapy goals for some of their patients, the therapists' opportunity to see tangible results of their work, and their sharpened awareness of their roles.

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Experimental Attitudes . . .

(*Continued from Page 60*)

SUMMARY

The major findings were as follows:

(a) As attitudes progressed from *active-friendliness* to *firmness,* the general positive effects on behavior decreased, especially with paranoid schizophrenics.

(b) Significant improvement in behavior was demonstrated in organic patients across all attitudes with greatest improvement under the most highly structured attitude.

(c) Schizophrenics showed positive changes in *cooperation* on all four attitudes with no other significant effects. As expected, this change was merely due to length of treatment and was completely independent of the experimental attitudes.

(d) Evaluation of progress notes indicating positive change in therapy was significantly correlated with improvement only in *cooperation.* Progress note measures were not correlated with any of the other four behavioral factors.

(e) Implications for more comprehensive evaluation of occupational therapy activity in psychiatric setting were made. The apparent "focusing" of therapists on *cooperation* as a criterion of improvement, plausibly, limited the effectiveness of evaluation.

(f) The MACC scale significantly differentiated the three diagnostic groups on *communication* and *total adjustment* with schizophrenics

being less communicative than paranoid schizophrenic and organic patients. The schizophrenics were significantly poorer on *total adjustment* when compared to organic patients.

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Psychiatric Recovery . . .

(*Continued from Page 66*)

What activities can this person perform and for how long? What hazards can he tolerate with reasonable safety?

To help the physician answer these questions the Social Adaptability Test is provided. A completed profile not only serves an employer in working out a safe adjustment for the person both on the job and in the home, but when placed in the hands of a housewife or person not gainfully employed it becomes equally valuable as a personal prescription for safer living to guide such a person throughout his daily activities.

Thus, in addition to treating the diseases and disabilities of his patients, the physician, by means of the specific method for evaluating social activity, can help the patient both to utilize and protect his abilities for a more rewarding and fuller life.

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ANNUAL REPORTS

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Los Angeles, California

November, 1960

BOARD OF MANAGEMENT MINUTES

Presiding: Miss Helen S. Willard, President

Minutes of midyear meeting, April, 1960, Milwaukee. The addition under special project fund committee report of a clause to include mention of a rotation plan in No. 3, organization of committee, was made. This addition under Yearbook proposal of statement omitted by the printer was made: "The Board requested that a competitive bid be secured from our current printer and indicated that any economical reduction would have to be considered. Final action is to be taken at the 1960 annual meeting."

It was voted to accept, as the official minutes of the June, 1960, interval Board meeting, the recorded listing of votes and recommendations which resulted from the deliberations.

EXECUTIVE REPORTS

Report of the treasurer, Miss Wilma West. Figures to date indicate our deficit may be less than projected. The education fund shows a surplus of $6400, reducing the accumulated deficit from $10,000 to approximately $4000.00. The year has been a satisfactory one and has re-established the good status of this fund. The $66,000 reserve fund is the largest ever shown but approximates by only one-third the amount necessary to operate the Association for one year. The Wollman Fund, administered by the AOTA for the New York State OT Asso-

ciation, will soon be transferred to the state, with the completion of their incorporation.

It was voted to accept the report of the treasurer.

Report of the speaker of the House of Delegates, Miss Ethel Huebner. Thirty-three member associations were represented at the meeting. No new associations have applied for affiliation. Mr. F. Wells McCormack, Association Service Office representative, reported to the House on the proposed AOTA group income protection and professional liability plans. Revised membership classifications, proposed by a study committee of the House and approved by House vote, will be transmitted to the Board for use in future revision of the AOTA constitution. The following recommmendations were submitted for Board action: (1) That financial assistance be granted toward expenses of the secretary and vice-speaker of the House to attend the annual conference, not to exceed $225.00 for each officer. (2) That Board attention be drawn to the concern of state associations over the Independent Living Bill and similar legislation affecting OT practice and that action at the national level be taken to insure awareness and appropriate steps. (3) That mailings of AOTA balloting material be sent first-class.

House decision on the following was reported for Board information: (1) A House opinion poll indicated that AOTA should employ a professional, non-O.T.R. consultant to study its structure and function, including committees. (2) A vote of confidence was expressed in the present AOTA publications and their editorships, and it was recommended that individual states' suggestions concerning AJOT be transmitted to the editorial committee. (3) All delegate mailings from the Speaker or the AOTA should also be sent to the alternate, state president, and district chairmen. (4) That state associations should be encouraged to utilize the experience of their past presidents. (5) That delegates should transmit to their associations the content of House discussion regarding utilization of the field consultant and recommend further consideration regarding the need for this service. Board action was as follows:

It was voted that the House of Delegates be urged to make its own decisions relative to allocation of expense funds, within their budgetary limitations.

It was voted with regard to the Independent Living Bill and similar legislation, that the committee on legislation and civil service be charged with the responsibility of studying this bill and possible state legislation in the same area, and of formulating appropriate recommendations.

It was voted that AOTA balloting materials be sent by first-class mail.

It was voted to accept the recommendations of the House of Delegates and the report of the speaker.

Report of the executive committee, Miss Helen Willard. The executive committee made the following recommendations to the Board: (1) That the detailed work of the national office personnel policies subcommittee, as reviewed and approved by the executive committee, be accepted for implementation. (2) Following extensive discussion, the executive committee recommended engaging an office management consultant to review the structure and function of the national office and its operation. It was further recommended, within the constitutional authority of the executive committee that this committee be empowered to implement the recommendations which in its judgment will best serve the needs of the Association.

It was voted to accept the recommendations of the executive committee.

Two items of executive committee action were reported: (1) Progress to date on investigations relating to the establishment of an investment advisory committee. (2) Appointment of Miss Margaret Gleave to serve as permanent conference chairman for 1961, following the resignation of Mrs. Winifred Kahmann.

Report of the executive director, Miss Marjorie Fish. The informational matters reported to the Board were: (1) Review of national office operation (as discussed under report of the executive committee). (2) Facts and figures, a statistical report on membership services and association enrollment. (3) Statistics on Yearbook publication, financial and other implications, and suggestions for financial improvement. (4) Increased grant received for final year of the curriculum study. (5) Cutbacks in recruitment and field consultant grants, from $57,000 to $34,000. (6) UCP grant for $10,000 received for undergraduate scholarships. (7) Field consultant in psychiatry to join staff in January, 1961.

Yearbook publication proposal, Miss Helen Mathias, associate director. Investigations have been conducted relative to possible reduction in the costs of the Yearbook publication: (1) Bids for a more economical format were submitted from our current publisher and the North Shore Publishing Company. (2) Expenditure of national office staff time in proofreading was questioned.

It was voted to authorize the present Yearbook publishing company to assume responsibility for the proofreading of the Yearbook and to table the decision relative to other changes until such time as expert advice is available from the office management consultant engaged to review the national office structure.

It was voted that the matter of changing the publishing company and the publication procedure be included on the agenda for the 1961 midyear meeting and that, at that time, consideration be given to accepting the offer of the North Shore Publishing Company for 1962.

Report of the council on education, Miss Angeline Howard. The council referred the following items for Board action: (1) From the committee on the SOP of the council on education: It was proposed that a chairman-designate of the council on education be appointed by the president-elect, preferably before December 31 of the year the president-elect assumes office. (2) From the committee on graduate study: The Board of Management was requested to ask the OVR for funds for: (a) graduate study on a five-year basis, to be increased each year; (b) travel funds for selected members of the committee on graduate study for a workshop to discuss graduate study. It was also recommended that the national office assume responsibility for the administrative aspects of the grant at the beginning of the 1961-62 period, with the screening and selection of candidates to remain the responsibility of the committee throughout the proposed five-year period. Recommendation (1) was accepted with appreciation by the Board, but no definitive action was necessary since this is a part of the operational plan already being considered.

It was voted that the AOTA request continuing funds from the OVR for graduate study traineeships on a five-year basis, the number of traineeships to be increased each year.

It was further voted that at the time this request is submitted, additional funds be requested for travel expenses of selected members of the committee on graduate study, to participate in a workshop on graduate study.

It was voted to table the recommendation concerning the administrative handling of grant funds and the screening of candidates, pending further clarification.

Report of the director of education, Miss Virginia Kilburn. Detailed reports were submitted. Council on education action on the revised RPSA forms was noted. Further council consideration will be given to this at the midyear meeting, after progress on new procedures has been evaluated. Total statistics on education office activities are available. No Board action was required.

Report of the editor of AJOT, Mrs. Lucie Murphy. The editor submitted data received on bids for the annual printing of conference proceedings as a separate publication. Reports were submitted on the feasibility of publishing the 1960 conference proceedings in a separate issue.

It was voted, in connection with the publication of future conference proceedings, that the expense involved should be pre-estimated and incorporated into the total estimated cost of the conference, thus determining the amount of the registration fee, and resulting in prepayment of the cost of publication.

It was voted to authorize the editor to publish the 1960 conference proceedings in a separate issue of AJOT.

It was suggested that information as to the availability of conference proceedings be published for the use of non-OTRs, as well as OTRs, indicating briefly the papers given and their content. The Board felt this was an excellent suggestion and indicated that such publication in AJOT would be discussed with the editor.

Report of the field consultant in rehabilitation, Miss Irene Hollis. A complete advance report had been submitted, with a summary of the year's work and a list of visitations. No Board action was required. A new role definition of the consultant's position was submitted.

Report of the director of public information and of the recruitment and publicity committee, Miss Fish (for Miss Hardy and Mrs. Shuff). Reports of the director of public information and the activities of the recruitment and publicity committee were distributed in advance. The committee proposed a resolution and recommendations but time did not permit sufficient opportunity for adequate consideration. Action on these will be taken by mail. A recent publication, THE BEST OF THE WORKSHOPS, was presented for Board information.

COMMITTEE REPORTS

International committee, Miss Marie Louise Franciscus. The international committee referred for Board action the problem of assisting therapists in foreign countries desiring to attend the congress but unable to do so without financial assistance or employment in the United States in a remunerative position. Board suggestions for such assistance included compilation of lists of clinical facilities offering employment opportunities; referral to state associations for the location of openings in key cities; questionnaires to ascertain both the possibilities of employment in the United States and factual information on applicants abroad; extension of existing traineeships; exploration of educational programs in hospitals having stipends available for such programs.

It was voted to accept the report, giving the committee assurance that the Board deems this plan appropriate, provided it does not imply association endorsement of the therapists involved.

Permanent conference committee, Mrs. Winifred C. Kahmann. The revision of the SOP for the permanent conference committee and reorganization of conference planning was distributed. Confirmed dates for future conferences were indicated as follows:

November 2-11, 1961, Sheraton-Cadillac Hotel, Detroit, Michigan.

October 20-25, 1962, Bellevue Stratford Hotel, Philadelphia, third congress WFOT and AOTA business meeting.

October 17-24, 1963, Park-Plaza Hotel, St. Louis, Missouri.

October 23-30, 1964, Denver-Hilton Hotel, Denver, Colorado.

It was voted to hold the 1965 annual conference in Florida, upon invitation from the Florida OT association.

The resignation of Mrs. Winifred Kahmann was accepted with regret and with expression of deep appreciation for her long and valuable services.

Committee on occupational therapy assistants, Miss Marion Crampton. The committee referred the following recommendations for Board action: (1) That the annual re-certification fee for occupational therapy assistants be set at $5.00. (2) That if this fee is not adequate, based on a cost accounting, it should be raised to cover all costs involved. (3) That the timing of the renewal of the annual re-certification fee should be worked out to not conflict with the workload in the national office and that preference be given for the calendar year. (4) That there be an inexpensive printed listing of certified occupational therapy assistants, by area, on standard size paper with the occupational therapy assistant imprint on the cover paper and with names and current employment locations forming the body of the information.

It was voted to accept the recommendations of the committee on occupational therapy assistants.

Committee on occupational therapy volunteer assistants, Mrs. Wilma Morrow. The committee presented a revised Guide for Training OT Volunteer Assistants, with revision emphasis on course curriculum, orientation, relationships and communication, and with less emphasis on crafts instruction.

It was voted to accept the report and recommendations of the committee with sincere appreciation (dissenting votes from Miss Bowing and Mrs. Fidler).

Clinical procedures committee, Capt. Lottie Blanton. The chairman advised the Board of changes in the personnel of the sub-committee. Capt. Blanton's resignation as chairman was received with regret. The Board was requested to consider whether the clinical procedures committee should continue to function as heretofore, or whether revision of the committee's scope and mission should be reconsidered.

It was voted to authorize the committee to redefine its scope and mission.

The chairman indicated the committee's willingness to assist the AOTA special committee on role definition with its assignment, provided it is given specific guidelines for what is to be done and the methodology of procedure. The committee requested that, as a clinical committee, they be given the opportunity to review the *OT Reference Manual for Physicians*, if and when it is revised.

Prevocational exploration committee, Mrs. Lilian Wegg (for Miss Helmig, chairman). The summary report of the committee concerned itself with the following areas: (1) Present status of prevocational units. (2) Strengths and weaknesses of present programs. (3) Research programs currently investigating the problem. (4) Need for an informative manual. (5) Need for a glossary of terminology. Projects under consideration by the committee were noted. It was the feeling of the committee that it is premature, at present, to submit grant proposals. Results of the proposed studies will

be presented at the 1961 annual conference, with a definition of goals.

It was voted to accept the report of the prevocational exploration committee with appreciation.

Development advisory committee, Miss Wilma West. Two matters were presented for Board information: (1) A revised statement of purpose with proposed wording: "The object of the association shall be to improve and advance the practice of occupational therapy and the education and qualification of occupational therapists. To further this object, the organization shall establish standards of performance, foster scientific research, promote the exchange of knowledge and engage in other activities advantageous to the growth of the profession and its members." The committee recommended the above version as being more patient-centered, to replace the current statement appearing in the constitution, article I, section 2.

It was voted to adopt the revised statement of purpose to replace the present statement appearing in the AOTA constitution.

(2) A progress report on committee work was presented, with the information that it is planned to terminate the study by November, 1961. An excellent resume of AOTA committees has been prepared by one of the members.

There was discussion relative to the possibility of utilizing the office management consultant who will be employed, for review and study of the national office, in the additional capacity of reviewing the total AOTA structure.

It was voted to accept the report of the development advisory committee with appreciation.

Project writing committee on director of professional development, Miss Martha Matthews. The committee submitted a revised prospectus for a director of professional development, covering the assumptions required, the role and function of the director, and the suggested structure and relationships.

It was voted to accept with appreciation the outline prepared by the project writing committee on the concept and scope of the proposed position of director of professional development. This is to be used in preparing a grant request for same.

Role definition study, Dr. Mary Reilly, interim chairman. The interim chairman reported that it would seem more timely to study the structure and function of the association first. She felt that role definition involves more than the clinical role of OT; that the committee should study the attributes of a hypothetical model of what a professional association should be; and that it should concern itself with external problems facing the association, as opposed to the internal problems being handled by the development advisory committee, even though the two are well related and both committees can proceed simultaneously. Board feeling was expressed that the matter of role definition has an important priority rating, both in terms of membership interest and in terms of correlation with the work of the development advisory committee study on structure and function.

The chairman's plan proposed the formation of approximately four groups of three persons each to study pertinent areas, which would include clinical specializations and the educational field. These groups would review recent changes in the profession, current problems and possible methods of tackling these problems. Their studies would be correlated by an over-all committee. There would also be formation of local groups to work on individual problems at a later stage. Specific persons were named for the original working groups. Board consensus indicated that the chairman should proceed with the formation of the working groups as outlined, with a progress report to be presented at the 1961 midyear meeting.

Statement of policy, Miss Naida Ackley. The chairman of the subcommittee on psychiatry of the clinical procedures committee had been requested, at the June, 1960, interim Board meeting, to ask her subcommittee to draw up a proposed statement of policy for the association. She reported that it had not been possible to secure full committee participation in the brief time period and that the resulting statement presented for Board consideration had the approval of only three of the six committee members. The point was made that the statement, as a whole is geared to occupational therapy in general, not to psychiatry in particular.

Extensive Board discussion ensued on some of the following problems: (1) The current situation, in which the role of occupational therapy is frequently determined on the basis of administrative efficiency instead of in the medical area. (2) The shift from a medical to a non-medical orbit, representing some loss of identity in the psychiatric area. (3) The strengthening of AOTA's organization and educational structure (development of leadership position for the therapy phase of activity). (4) The problem of determining acceptance of the statement of policy, either as an expression of what the AOTA desires for itself, or in terms of its effect on other organizations.

Considerable deliberation centered on whether the AOTA was in a position to make a strong statement of policy on its own, or whether it would be preferable to have the role of occupational therapy defined through the authority and with the support of a body such as the American Psychiatric Association. Further opinion was expressed that no administrator should negate or defeat the treatment purpose of occupational therapy by failing to provide appropriate coordination or relationships between registered therapists and non-medically-oriented activity workers.

It was voted (dissenting vote by Miss Huebner) that the policy as presented by the subcommittee on psychiatry of the clinical procedures committee be accepted with the following change, "designed to make it more acceptable to all" (addition requested by Miss Huebner to clarify her dissenting vote): in the section listing the six obligations and responsibilities of the AOTA, a seventh be added as follows, to replace the remainder of the proposed statement: "(7) Strongly oppose and protest any administrative policy or structure which ignores or weakens the treatment function of the occupational therapist."

The Board agreed that the accepted statement of policy should be sent to appropriate persons in the American Psychiatric Association, the American Medical Association, as well as the AOTA Medical Advisory Council. It should be requested that they expedite action by their committees to define the roles of the different groups, and that we ask their support and recognition of occupational therapists as a treatment group.

OTHER BUSINESS

Report on the 1960 meeting of the AOTA medical advisory council: The present membership of the medical advisory council was reviewed for Board information. The deliberations of the medical advisory council included reports on two meetings at which AOTA was represented: American Medical Association committee to study relationships of medicine with allied health and professional services; executive committee meeting of the American Academy of Orthopedic Surgeons. Consideration was given to the recently published *Occupational Therapy Reference Manual for Physicians,* and critiques were presented by the physicians. Other agenda items included a report on occupational therapy assistants, a

report from the field consultant in physical disabilities, and group and professional liability insurance.

Proposed position of conference coordinator. The position of conference coordinator has not yet been finalized and is still under advisement relative to personnel available, financing, and reallocation of some of the responsibilities and areas of supervision in the conduct of conferences. It is felt advisable to defer permanent change until recommendations are available from the management consultant .

It was voted that the executive committee be empowered to make final decisions, in consultation with the local conference chairman, for solving the immediate problem (1961 conference) relative to permanent conference chairman and conference coordinator.

Group and professional liability insurance. Mr. F. Welles McCormack of the Association Service Office presented a summary of the investigations relative to procuring an appropriate insurance plan for the members of the Association.

It was voted to accept the group income protection and professional liability insurance plans as presented by the Association Service Office. *It was further voted* to authorize the president and executive director to sign the agreement with this organization.

World Federation of Occupational Therapists, progress report on 1962 congress, Miss Marie Louise Franciscus. A report was presented in the absence of Miss Margaret Bishop, convenor of the congress, and is available in the files.

Reactivation of the interdisciplinary study group. At the June, 1960, interval meeting of the Board, it was recommended that there be a reactivation of a type of interdisciplinary study group to insure contact with other activities groups. Viewpoints expressed by the medical advisory council at their 1960 meeting were reviewed: (1) The importance of non-interference or duplication with work of the AMA committee on relationships of medicine with allied health professions and services. (2) The fact that an interdisciplinary study group could be dangerous if set up as an administrative power, but worthwhile if it were to be done as a means of communication between the different groups. (3) The question regarding the basis for determining representation and doubt as to whether the groups previously represented had been sufficiently oriented medically.

Board discussion pointed out the bases for group representation as being patient-centered and representation from official organizations. A difficulty encountered by the previous study group was cited as being an insecure organizational structure which made it difficult for them to carry out assignments. It was felt that representation for any proposed group would have to be determined very carefully.

It was voted to postpone decision, for the time being, on the reactivation of an interdisciplinary study group.

Correspondence with the American Psychiatric Association. In accordance with action taken by the Board at the June, 1960, interval meeting, a letter was sent to the American Psychiatric Association's president, Dr. Felix, expressing the concern of the AOTA with regard to current practices in psychiatric occupational therapy. No official reply has been received.

Midyear meeting, 1961. The 1961 midyear meeting of the Board of Management will be held in Akron, Ohio, March 23 to 26. A schedule for an interim meeting of the Board will be decided at that time.

Respectfully submitted,

Marjorie Fish, O.T.R.
Executive Director
Secretary to the Board.

INTERIM REPORT ON THE CURRICULUM STUDY

(The following report was introduced and concluded by Wilma L. West., O.T.R., director of the curriculum study. Separate portions of it, as indicated in the text, were given by Carlotta Welles, O.T.R., and Mary Booth, O.T.R., directors of the job analysis and educational phases, respectively.)

Two years ago last month, the Association inaugurated the curriculum study. Next year at this time, all data related to this project will have been analyzed and the final report, barring now-unforeseen emergencies, published.

At the present stage, which occurs just after completion of data-collecting but before significant inroads have been made in the data-processing and analysis on which results will hinge, it has been difficult to know how and what to report.

At the present inconclusive stage of the total study, we are neither able to see impressions in context, nor are we at liberty to report such until all data have been processed and analyzed for the final publication. We feel sure that you will interpret this reservation on our part as a basic principle in any kind of research and as a means of protecting our own and the study's integrity by avoiding premature and possibly ill-founded statements. For purposes of the present report, therefore, we will comment primarily on other aspects of the study's design and development to date. With respect to more than two-thirds of it, we can report with some perspective on a nearly complete data-collection phase and a well-underway data-compilation phase.

At the outset, we should note that the term "curriculum study" is an incomplete description of the project since it implies involvement of just OT schools. Our Association's curriculum study was designed to analyze the job of the occupational therapist and to match this, together with other criteria, against the instructional patterns which have developed in schools and student affiliation centers to prepare for that job. Thus a major and basic premise of the study has been its concern with an analysis of the practice of the therapist as well as analyses of both the academic and clinical portions of the education of the student. By studying these, both separately and in relation to each other, it was hypothesized that we could deduce the functional status of the curriculum—in a word, the degree to which our education prepares us for the jobs we are doing—and on this basis, be able to make recommendations for further development of academic and clinical curricula.

Carlotta Welles served on the project staff in the capacity of director of the job analysis phase. Miss Welles' report pertains to the design, technique and selected other aspects of this part of the study.

* * *

Job Analysis report, Carlotta Welles, O.T.R.

Basic to the study is the concept that education for occupational therapists should be built on the need for that education—in other words, on what occupational therapists are, what they do, and on what they might or could do. The job analysis section of the study was therefore designed to find out in careful detail what representative therapists in representative centers are doing. In the compilation phase this becomes one criterion for what they need to know and what should be built into academic and clinical curriculums.

From the 1292 clinical centers in this country employing approximately 2500 qualified occupational therapists, 50 centers were selected as representative of their location,

size, specialty and type of support, (Veterans Administration, voluntary, etc). Criteria used in selecting the 150 therapists to be interviewed in these centers included: length of experience, school of graduation, and area of specialization or assignment. Areas included the usual five plus geriatrics, mental retardation, sensory conditions, and a variety of supervisory and administrative functions. The selection was a statistical process, not a qualitative one; selection or non-selection therefore did not imply any value attributable to the centers or therapists concerned.

The data-gathering process was an undertaking in which many therapists from Boston to California participated. A representative field committee helped in preparing a frame of reference which included all possible duties and areas of function of an occupational therapist. This frame of reference then served as a guide in collecting data and in its subsequent reorganization.

Methods used to find out what occupational therapists do included the interview and the critical-incident technique. Miss West and I received some training in interviewing and did a few trial runs under the supervision of a consultant in job analysis. Then she accompanied me to eight centers where she listened to 23 interviews, and wrote them up. She will also listen to tape recordings of 37 more and write up these. This then provides for a dual write-up of 60 of the 150 interviews and gives a reliability check of 40% to insure that material collected represents the ideas of the respondents rather than those of the interviewer. It was emphasized that the interview was a data-collection process, not an evaluation. There were no right or wrong responses.

The second method, the critical-incident technique, involved the collection of 1500 examples of performance of therapists. These came from centers visited as well as from the 20 independent teams working throughout the country. Two-thirds of these incidents described effective performance and one third, ineffective. Nearly 33-1/3% related to psychiatry, 20% to physical disabilities, and 20% were distributed in approximately equal proportions among the diagnostic areas of general medicine and surgery, tuberculosis, pediatrics and cerebral palsy. Finally, it is both interesting and significant that 25% of the incidents collected dealt with the purely administrative and educational roles of therapists. When analyzed, again with the help of field teams, these incidents will furnish additional data on what occupational therapists do, and thus will provide more information on what they need to know.

While visiting these 50 centers the interviewer also talked with administrators and physicians to gather data pertinent to the growth of occupational therapy. Four areas were explored with 80 such "users" of our services: education and research going on throughout the center; supervision given to occupational therapy; their concept of its major roles; and their recommendations for our education. This material, when compiled and integrated with like data collected from occupational therapists themselves, should provide one interesting and valuable basis for clarification of both function and preparation.

Finally, it was believed essential that recommendations for curriculum be based on what occupational therapy ought to be. Moreover, though data was sought from many different sources during the study, these concepts must come from the profession itself. Therefore, data pertinent to the growth of occupational therapy was also gathered by a questionnaire on "ideal practice," which was sent to several hundred therapists. Its length and complexity reflected the complexity of occupational therapy itself.

Thus therapists everywhere have helped gather an immense amount of material on what occupational therapists are doing and may do. Work going on at present includes the processing of data collected in each interview so that it may be compiled with that collected from the schools and student affiliation centers. Also methods are well underway for compiling the quantitative data gathered on the many forms used.

If this section of the curriculum study can give you anything now for your use, it would be in the form of an idea, and some tools. Socrates said, "The unexamined life is not worth living." What about the unexamined patient? The unexamined treatment plan? The unexamined program? The areas which some of you have been examining with us include concepts, objectives, services, methods of evaluation, and plans for growth. As the participants well know, asking questions and listening creatively to ideas take time. Listening also implies *hearing* without criticism, and without approval. To do either is to evaluate. As the participants also found out, the process of thoughtful examination is productive of new insights and new answers.

The most basic question confronting us all today is, "What is occupational therapy?" This is not asked in expectation of a simple definition, but rather with the hope of clarifying its concepts, its objectives, and its services. How does it evaluate its effectiveness? What are its plans for growth? You have asked these questions, and you have answered as you worked on committees, as you wrote papers, and as you developed your programs.

* * *

Miss West: Concurrently with the development of data-gathering materials and procedures for the analysis of practice was the structuring of techniques for the survey of education, both academic and clinical. Since we wanted to draw the maximum possible number of interrelationships between these two major phases of the study, our techniques for collecting information had to be essentially the same in each. Similarity of objective and technique notwithstanding, however, the curriculum phase had its individual scope and experience. Mary Booth, director of this part of the study, will tell you something of these.

* * *

Curriculum Phase, Mary Booth, O.T.R. It would be interesting to know how many miles were covered by the staff of the curriculum study project. My own share was over 25,000.

Between us, Miss Abbott and I visited 21 schools offering OT curricula, thus leaving five to be surveyed during the coming year. At each school we interviewed the dean and/or president of the institution to learn the over-all objectives of the college, the place of OT within the institution, and his recommendations concerning the trends of occupational therapy education. The senior students answered a questionnaire relating to the climate of the college, their most and least meaningful educational experiences, and the concepts they had learned about the major fields of study. In an effort to find out not only what is being taught OT students but how it is taught, how students are evaluated, what students are expected to know at the completion of the course and how courses are related to each other, we interviewed most of the instructors teaching OT students, (MD's, OTR's and specialists in academic fields). In addition, we asked the school heads how they taught such topics as management skills, how they handled coordination with the affiliating hospitals, and what they thought the profession should be doing.

Before our arrival at a school, the director there sent out course data sheets to each instructor with a request for outlines, syllabi and copies of examinations. The great quan-

tity of material we have accumulated is evidence of how well they did their job even though the material for every course is not complete. In addition, each director made appointments for some 30 to 40 interviews which lasted from 45 minutes to one hour each. On the basis of a 40-hour week, this kept us busy. Sometimes all the meetings were held in one room, but more frequently a staff member had to lead us from one office to the next.

The courses investigated through these interviews were selected on the basis of the AMA minimum essentials, i.e., anatomy, physiology, kinesiology, psychology, medical lectures, theory and media. With rare exceptions, the instructors from the presidents on down were extremely interested in the project and whole-heartedly gave us all the help they could. This wasn't always easy since some of the doctors gave only three of a long series of lectures, and of necessity could only give us a partial picture of the course. Some teachers were giving a required course for the first time and naturally had considerable difficulty in answering many of our questions. We even met one OTR who had been teaching for only two weeks.

As a continuation of the study of the education of occupational therapists, we visited 50 hospitals having student affiliation programs. Of the 246 centers training students we eliminated 40 because they trained only one student a year. Of the remaining 206 we selected the most used centers: two for each school. This gave us a picture of how most students are trained. It also gave us a geographical spread from New York to San Francisco and from Houston to Minneapolis. It included military, VA, university, state and private hospitals, as well as a sample of hospitals covering the five common diagnostic categories. We surveyed 11 hospitals or services for psychiatry, 14 for physical disabilities, 9 for GM/S, 9 for pediatrics and 7 for tuberculosis. In each institution we interviewed the OT, his medical and/or administrative supervisor, and the students. We asked the MD's about the objectives of the institution, their relationship to the OT department and the student training program, and their suggestions for future planning. In a written questionnaire, the students described specific experiences they had had in the center. The clinical training supervisor explained what he was teaching the students in the following four areas: orientation, patient treatment, organization and administration, and media. We also asked the student supervisor *how* the subject matter was taught to the students, how the student was evaluated and what he expected the student to know at the end of the affiliation. Such topics as coordination between school and center, student guidance and future planning were covered with the supervising therapist.

In order to check the reliability of our material, we interviewed in pairs part of the time and tape-recorded the interviews part of the time. This was an attempt to show that the material we collected was not biased by the interest and background of the interviewers. Working on the curriculum study project has not only provided us with an opportunity to learn a variety of techniques related to research, but has given us a picture of the many different settings in which OT functions. In addition, we met and talked to many interesting people both within and without the profession. We interviewed Dr. Walter Barton, president-elect of the A.P.A., who feels that the increase in out-patient facilities for the mentally ill will change the job of an OT from a therapist to a supervisor of craftsmen and other activity specialists. We interviewed Dr. Linden F. Edwards, the author of "A Concise Anatomy" and attended one of his lectures. We also interviewed Dr. Fritz Redl, who had just returned from a research project at the National Institute of Mental Health in Bethesda, Maryland.

Last but not least we met fellow OT's all over the country. They planned our schedules for us; they spent long hours giving us their best thoughts on what they were doing and what they hoped to do professionally; and they entertained us. We want to thank each of you who participated in the project. Without you we could not have begun, much less completed the field survey phase of the curriculum study.

* * *

Miss West: As noted by Miss Booth, five of the schools of occupational therapy remain to be surveyed but, aside from these, all other field work was completed in June of this year. Since July, the staff have been working on the third and final phase of the study —that of compiling the data for analysis and the formulation of recommendations for revision of curriculum. A few comments on this aspect of the study will conclude this interim report.

How does one go about compiling data of this kind? The volume alone is staggering. Twenty-two separate forms were used in the three phases to insure collection of standard materials via both the formal questionnaire such as was completed by students and the less formal though still structured interview used to elicit data about what the student is taught in school and what the graduate is asked to do on the job. The smallest number of completed forms obtained from use of *one* of these instruments is 26, representing the size of the schools' sample; the largest is 1500, this being the number of examples of performance collected by the critical-incident technique; there are 20 other forms whose numbers range from 50 to 320.

The use of mechanical methods of processing, for example IBM cards, has been ruled out for handling any appreciable portion of these data for two reasons. First and most obvious of course is the fact that the project did not involve the kinds of numbers which make IBM methods a logical economy. Even if the study had included every therapist in the country rather than the relatively small sample to which we were limited, it is highly doubtful whether these methods would have proved suitable for our use. The edge of our disappointment in being blocked from this "easy way out" was somewhat tempered when we received IBM's cost estimates of $400 per month for rental or $45,000 for outright purchase of the minimum essential equipment.

A second factor contraindicating use of mechanical processing methods was the character of the data sought and obtained in the curriculum study: the bulk of this was qualitative rather than quantitative in nature. To illustrate: questions asked in schools and student affiliation centers were "What do you teach? How do you teach this? How do you evaluate the effectiveness of your teaching? And what is your estimate of the learning level acquired by the student?" In the analysis of practice, we asked "What do you do? How do you do this? Why do you do it? And how do you measure the success of what you do?" Obviously, answers to these kinds of questions do not lend themselves to statistical tabulation but will, instead, require the use of analytical and qualitative methods of processing. Although these are more demanding of both time and mental application, they are obviously essential if we are to derive from the curriculum study more detailed information on the function of the therapist than exists in the job descriptions of hospital personnel departments, and more enlightening data on curriculum than can be obtained from college catalogues. Such was the philosophy and purpose of the study and such was the design of the techniques employed to collect data. At the current

stage of data-compilation and processing, we must assure use of methods permitting the kinds of analyses on which sound and realistic recommendations can be based. Our record to date in this phase of the processing includes development of a structure for and completion of a sample processing of six of the qualitative type forms.

For that portion of the data which is quantitative in nature (forms which identify, classify and factually describe individuals, institutions, courses, programs and the like) we hope to use the McBee Key-Sort system. This process involves the use of coded and punched cards from which various "sorts" can be made by inserting a knitting needle through the selectively punched holes. To date, we have identified possibly ten of the survey's forms which can be tabulated by this method and five of these have already been structured and coded for transfer to the cards which will make the matter of sorting for any single factor or element possible in a matter of seconds. Adding these five quantitative forms to the six qualitative instruments already referred to, we are thus approximately half the distance to the goal for this phase. It is currently estimated that another four to five months will be required to complete the balance of the processing, thus leaving approximately equal time for the deductive and interpretive analysis which will shape curriculum recommendations to be included in the final report.

We hope this brief and necessarily inconclusive report offers some insight into the purpose and method of the curriculum study, if little more than a glimpse of the kinds of results we hope to achieve. These we dare not predict—even among ourselves, though the temptation is frequent and strong—lest we structure our processing methods to yield an hypothesized result and then force the data to fit a preconceived structure or pattern. Rather, we must proceed on the longer but safer route of deducing the structure from the data and then of compiling, comparing, analyzing and, finally, reporting the ultimate curriculum recommendations.

Regardless of what these may be, the very fact that the curriculum study was undertaken is cause for pride in the professional integrity which prompts this kind of self-evaluation. In the compilation of these data, we have amassed a wealth of information on education and practice not previously available in either separate or inter-related form. In the analysis and interpretation of data, we hope to formulate recommendations, possibly heretofore theorized but never so extensively documented, that will lead to improved concepts and methods of professional preparation. And, subsequent to publication of the data, we anticipate that the same enthusiastic and cooperative effort which has characterized the study to date will see us through acceptance and implementation of whatever revisions are worthy and possible of adoption.

On behalf of the study staff, our sincere and grateful thanks to the hundreds of therapists who gave generously of their time and thought to provide the data requested of schools, student affiliation centers and clinical departments, and to additional hundreds who participated in the writing and analysis of the critical incidents and completion of the questionnaire on ideal practice.

On your behalf, and mine, appreciation is due Marguerite Abbott, Mary Booth and Carlotta Welles for the miles they logged, the questions they asked, the reports they wrote and the study they devoted to determining "What is the job of the occupational therapist and, therefore, what is the education best designed to prepare him for that job?" The answers to these questions will write the final report on the curriculum study.

Wilma West, O.T.R.
Project Director

DELEGATES DIVISION

ARKANSAS

Delegate-Reporter, Ruth L. Melsheimer, O.T.R.

The Arkansas Occupational Therapy Association meets monthly except in December and through the summer. Our main and continuing effort is for recruitment in our state. Each high school counselor over the state receives literature with a personal letter enclosed that offers additional information through speakers and film. Mrs. Margaret King, O.T.R., serving as recruitment chairman has also mailed to the private religious schools. The stuffing and addressing of envelopes has been done as a group project as our association is small and all hands are needed. Our membership at this time consists of nine registered members and two associates. We participate in various career clinics that are held in Little Rock—or any other place if we receive an invitation or know about it soon enough to ask to be a participant.

The program meetings have been varied and business sessions were held as needed.

OFFICERS

President .....Virginia Stockwell, O.T.R.
Vice-President .....Helen Wood, O.T.R.
Secretary-Treasurer .....Doris Simpson, O.T.R.
Alternate Delegate .....Ruth Melsheimer, O.T.R.

INDIANA

Delegate-Reporter, Margaret L. Smith, O.T.R.

In Indiana, each of the forty-two active members of the Association participates in the recruitment efforts of the public relations committee, since the work is distributed among numerous sub-committees. The following projects were completed during the past year: an open house for high school students was held in a rehabilitation center; members participated in numerous career days, gave talks and conducted tours for a variety of organizations; an exhibit depicting six phases of occupational therapy was purchased with funds donated by the Indianapolis Foundation; two occupational therapy training courses for Girl Scouts were completed; and literature was distributed to high schools and public libraries. We are also proud to announce that the first class in ocupational therapy graduated from Indiana University.

Widespread participation in the Association's endeavors has also resulted in the following:

(1) The IOTA Newsletter, published quarterly, describes the activities of the Association and its members, and helps to unite the Indianapolis group with the northern district and therapists in outlying areas.

(2) A variety of topics was presented for association meetings: research, recruitment, ethical practice in occupational therapy, wheel chairs, city planning, and proprioceptive facilitation techniques.

(3) Substantial profits were realized from our annual card party, a dinner meeting, and the sale of ceramic tiles.

(4) All members received the annual membership booklet, and continued efforts were made to increase membership in the Association and attendance at meetings.

(5) A manual of standard operating procedures for all officers and committee chairmen was prepared to facilitate an efficient transfer of those positions.

During the coming year emphasis will be placed on therapists and their accomplishments with all programs being planned to feature therapists.

OFFICERS

President ..... Elaine Bates, O.T.R.
Vice-President ..... Patricia Laurencelle, O.T.R.
Secretary ..... Barbara Babcock Koch, O.T.R.
Treasurer ..... Barbara W. Hamilton, O.T.R.
Delegate ..... Margaret Smith, O.T.R.
Alternate Delegate ..... Judith Harris, O.T.R.
Public Relations Coordinator.... Dorothy W. Main, O.T.R.
Chairman, Northern District ..... Elaine DeVries, O.T.R.

LOUISIANA

Delegate-Reporter, Garnet Hines, O.T.R.

To expedite the transmission of information to the members of the Louisiana Occupational Therapy Association, a news bulletin was started by Mrs. Ruth Metcalfe, vice-president of the Association. Through this publication we share ideas and learn of the work of other therapists. There are reports of special events, information regarding the history and functions of related organizations in which our members participate, and the delegate reports of current events pertaining to the House of Delegates and the American Occupational Therapy Association. Since the initiation of this bulletin, less time is needed for ordinary business discussions at the quarterly meetings and more time can be devoted to essential business.

The foundation for a scholarship fund has been laid. Miss Lottie Stephens, occupational therapist from the Louisiana Central State Hospital, has given money and time to promote this project.

For recruitment and publicity, the state has been divided into five regions with a committee and subchairman for each area. Mrs. Ruth Metcalfe, state chairman, has conducted special planning meetings with these groups. They are never idle. Occupational therapy is presented to the public in various ways. They talk occupational therapy to all interested groups: state, college and high school counselors, college and high school students, hospital volunteers, Parent-Teachers' Associations, Rotarians, garden clubs, church groups, teenagers and professional groups.

Other media used are radio and television, newspapers and organization magazines, special art exhibits and booths at the state fair. The Southeast Louisiana Hospital had an opportunity to present occupational therapy to the public in a unique way. At Mardi Gras time, the adolescent unit, sponsored by the occupational therapy department and a group of volunteers, designed the costumes and float and participated in a parade in a nearby town. It won first prize.

Supplemental to posters and other display materials prepared by the local recruitment committees and the national association, we have the "OT Story" and a special pictorial exhibit compiled by Mrs. Helen Shannon. This exhibit consists of photographs of the work that is being done in some of the occupational therapy departments throughout the state. The pictures are mounted individually but connected to become a single unit.

Mrs. Kathryn Long, chief of the occupational therapy department at the Southeast Louisiana Hospital, was active in a hospital program in which the staff of the hospital conducted a six weeks orientation course (for credit) for the senior class in a nearby high school. (This is the first course of its kind to be offered anywhere in the nation.) The purpose of the course was to give the students a better understanding of mental illness, its aspects and its treatment. Lectures were given at the school by psychiatrists, psychologists, nurses and recreational therapists. Mrs. Long represented the occupational therapy department.

The Louisiana Association was fortunate to have Irene Hollis, O.T.R., as the principal speaker at the first 1959-60 quarterly meeting, and as a guest in many of the occupational therapy departments in the state. Helpful advice on specific therapeutic problems and her enthusiasm for her work and ours were a stimulus to all of us.

OFFICERS

Vice-President ..... Ruth Metcalfe, O.T.R.
Secretary ..... Kathryn Long, O.T.
Treasurer ..... Nan Richards, O.T.R.
Historian ..... Donnis Jenkins, O.T.
Publicity and Recruitment ..... Ruth Metcalfe, O.T.R.
Delegate ..... Garnet Hines, O.T.R.

MARYLAND

Delegate-Reporter, Ruth G. Keyes, O.T.R.

In the Maryland Occupational Therapy Association this year special emphasis has been upon recruitment. Our committee continues to work closely and effectively with the recruitment committees of the association of Maryland physical therapists, medical technicians, and social workers. This joint committee did excellent work in preparing exhibits and presenting information and materials on careers in the health field to various state groups including guidance counselors, teachers, and students. The efforts of this joint committee are paying dividends already in that it was requested to carry two sessions of a career workshop for teachers in the Baltimore city board of education. In preparing for these meetings a hospital administrator was called in as consultant and he moderated the sessions. Through the hospital administrator, contact was made with the local hospital council which is interested in the joint recruitment effort and plans further work with us in this direction.

Two interesting subjects covered in regular meetings were the World Federation of Occupational Therapists and the role of the occupational therapist in civil defense. Miss Clare S. Spackman, O.T.R., and Capt. Barbara Knickerbocker, AMSC (OT), respectively, were guest speakers for these meetings.

Our annual joint occupational therapy and physical therapy meeting was in the form of a dramatic presentation and discussion of the legal aspects of records directed by an attorney. The lawyer pointed up our weaknesses and strengths in such effective fashion that therapists present were made more acutely aware of the importance of accuracy in notewriting.

OFFICERS

President ..... Elizabeth S. Grayson, O.T.R.
Vice-President ..... Jean Gosselin, O.T.R.
Secretary ..... Lillian K. K. Chong, O.T.R.
Treasurer ..... Frances L. Dunlap, O.T.R.
Delegate ..... Ruth G. Keyes, .O.T.R.
Alternate Delegate ..... Nina L. Hartline, O.T.R.

The illustration accompanying the article entitled "A Study Toward a Theory of Neuromuscular Education Through Occupational Therapy," published in the March-April, 1960, issue of AJOT was reproduced incorrectly. For a full description of the chart, interested readers may contact the author, Mrs. Patricia Curran Ostrow, O.T.R., occupational therapy department, University of Southern California, Los Angeles.

REVIEWS

FRACTURES AND ORTHOPAEDIC SURGERY FOR NURSES AND PHYSIOTHERAPISTS. Arthur Naylor. Baltimore, Maryland: Williams and Wilkins Co., agents for E. and S. Livingstone Ltd., Edinburgh and London, England, 1960, 358 PP., $6.50.

Here is an excellent book on orthopedic conditions primarily for the orthopedic surgeon and other physicians rather than for nurses and physical therapists as the title suggests. The author merely points out that certain procedures will or will not benefit from therapy or will require certain nursing methods, but rarely does the book go into detail about various therapies or nursing techniques suggested. Nevertheless, this does not limit the value of this book to therapists and nurses. They will certainly be enlightened by its contents, and they will gain valuable insight into the importance of their roles in the treatment of orthopedic conditions.

Many of the main orthopedic conditions and treatments are aptly defined, described and explained. The book is well illustrated.

—Lester M. Brower, M.A., O.T.R., R.P.T.

ATLAS OF HUMAN ANATOMY, Franz Frohse, Max Brodel, Leon Schlossberg. New York: Barnes and Nobel, Inc., 1959, 180 PP., $2.95.

This pocket-sized, paperback guidebook contains the well known Frohse-Brodel wall charts, 104 illustrations and numerous other charts. The charts are in eight different colors.

Here is anatomy presented in a compact way. Only main points are covered. Like any compact item certain things are sacrificed. Quantity, depth and detail are replaced for brevity, economy and size. However, this doesn't detract from the value of this book. For the person with an anatomy background, this book is an excellent brisk review. For the layman it is a good beginning. For the anatomy student and the practitioner the charts found in the book are valuable as a ready reference guide.

—Lester M. Brower, M.A., O.T.R., R.P.T.

ANATOMY AND PHYSIOLOGY VOLUME 2, Edwin Steen, Ph.D., Ashley, Montagu, Ph.D. New York: Barnes and Noble, Inc., 1959, 314 PP., $2.50.

Volume 2 contains the urinary, respiratory and nervous systems, sensations and sense organs, endocrine and reproductive systems. Only main facts about these topics are presented. Much detail is omitted. This paperback, pocket-sized book contains numerous illustrations, applications to disorders and disease, reference tables and some recent changes in terminology.

If the reader keeps in mind the advantages and disadvantages of compact pocket editions, this book can be useful.

—Lester M. Brower, M.A., O.T.R., R.P.T.

SEEING EYE WIFE. Virginia Blanck Moore. Philadelphia: The Chilton Company.

"Seeing Eye Wife" is well worth anyone's time for reading whether working with blind or sighted people. Virginia Blanck worked for the Iowa Commission for the Blind when she married Robert Moore, one of the blind rehabilitation counselors. This is the story of their marriage, the everyday problems and adjustments that occur when one of the couple is blind. Mr. Moore, in his job, contacts industries to place blind workers and therefore encounters and has to try to counteract the many misconceptions people have about blindness. The book portrays in a very real way the problems of the blind, both physical and emotional, injecting humor and understanding.

—Virginia R. Stockwell, O.T.R.

THE GENTLE LEGIONS. Richard Carter. New York: Doubleday and Company, 1961, 312 pp., $4.50.

A timely and candid book which should be of considerable interest to health and welfare personnel, as well as to all Americans. It is a volume which encompasses a thorough and up-to-date study of voluntary health organizations operating within the United States.

In a lively manner, the author presents a comprehensive report which includes: a review of the development of attitudes toward charity and the evolution of charitable organizations; a revealing set of facts regarding major and minor health organizations within our country; illuminating descriptions of the details involved in fund raising (with emphasis on the role of the volunteer); an objective account of the problems facing these organizations; and a close look at the controversial United Fund issue.

In the author's own words, "The purpose of the book is to provide . . . knowledge so that an informed public can decide for itself (a) whether it has been financing health research and related undertakings in a sensible way and (b) what needs to be done in the future."

THINGS TO MAKE FOR CHILDREN. A Sunset Book. Menlo Park, Cal.: Lane Book Company, 1961, $1.75.

A well illustrated book of ideas for interesting and entertaining projects for children. The wide range of ideas includes puppets, handcrafts, outdoor activities, and holiday displays. Although written for parents, its many suggestions and clearly pictured samples will be welcomed by occupational therapists.

LONG-TERM CARE IN THE GENERAL HOSPITAL: Its Effect on the Physical Therapy Department. Davis Littauer, M.D. *The Physical Therapy Review*, Volume 40, Number 9 (September) 1960.

We are witnessing an irresistible trend for the general hospital to establish services for the chronically ill in addition to those now offered for the acute patient. These developments will affect the physical therapy department and the therapist of the general hospital in the following ways:

1. Physical therapy will be used more extensively by the practicing physician for a greater variety of conditions.
2. There will be greater emphasis on restorative services.
3. Rehabilitation diversions will be established in general hospitals.
4. The physical therapist will be less isolated and will be an important member of a health team.
5. Continually higher standards of performance will be required of the individual therapist.
6. It will be necessary to train auxiliary workers to perform some tasks now carried out solely by qualified therapists.

(These developments will undoubtedly have similar effects on occupational therapy departments and therapists).

—Maryelle Dodds, Major, AMSC, M.A.

RECREATION AND PSYCHIATRY. A publication of the National Recreation Association, 8 West Eighth Street, New York 11, N. Y., 1960, 36 pp., $1.25.

Four theses by well-known psychiatrists are presented in this pamphlet: James S. Plant, M.D., "Recreation and the Social Integration of the Individual"; William C. Menninger, M.D., "Recreation and Mental Health"; Alexander Reid Martin, M.D., "Recreation: A Positive Force in Preventive Medicine"; Robert J. Campbell, M.D., "How to Use Recreation Activities as a Therapeutic Tool."

—Bertha J. Piper, O.T.R.

THROUGH THE BARRIERS OF DEAFNESS AND ISOLATION. Boris V. Morkovin, Ph.D., New York: The McMillan Co., 1960.

This book will be useful both to parents of hearing impaired children and all those who work with them in any stage of their development. It stresses the team approach to learning of speech. All members of the team must have an understanding of the extent of the barriers of deafness and its social isolation. The book was written by a number of writers—a psychologist, an otologist, an audiologist, parents, teachers and therapists, all of whom share the belief of the importance of oral communication, the need for early utilization of every training opportunity, and in developing the maximum of the child's sensory and mental potentialities.

Actual experiences and methods used are included in the text. There are suggestions of books, stories, periodicals, as well as a list of specialized hearing services, schools for the deaf (both residential and day) and a listing of the member agencies of the American Hearing Society.

—Virginia R. Stockwell, O.T.R.

AN APPROACH TO OCCUPATIONAL THERAPY. Mary S. Jones. Butterworth and Company Ltd., 1960, 245 pp.

The general assumption that the lower extremities belong to physical therapy and the upper extremities to occupational therapy is seriously challenged by *An Approach to Occupational Therapy.* The caseload described has only 10% upper extremity; the other 90% are lower extremity and spinal injuries, with a few cases of ulcers, heart conditions, etc. Mrs. Jones surveys the use of occupational therapy at Farnham Park Recuperative Home, Farnham Royal, Bucks, England. This is a residential center and a half-way house between the hospital and re-employment. The average length of stay is ten weeks and patients must be able to get about and care for themselves in order to be admitted. With an average daily attendance of about seventy-five patients, occupational therapy is carried out with one senior therapist, one assistant and one technician.

The book describes the floor plan and equipment of the occupational therapy department as well as the activities and adaptations used in treatment. Woodwork, metal work, gardening, leather and machine sewing are most commonly used. Patients make articles for their homes and much of the equipment of the department. Because of the type of patients there is little use for daily living or homemaking activities. The importance of psychological factors and posture are stressed.

The objectives of treatment of these cases include development of strength, mobility, endurance and practice of basic activities learned in the physical therapy department. Although the equipment is used as pure exercise when indicated, the overall impression is of the use of industrial related activities adapted to the needs of individual patients.

The usefulness of the book is increased by excellent photographs of patients at work and by diagrams of much of the special equipment used in the shop. Unfortunately, because of the lack of details it is sometimes difficult to tell exactly how the adaptations were constructed.

The brief case histories add to the interest of the book and for this reason would make it a valuable supplementary reader for occupational therapy students. Therapists working in the field will find many suggestions for adapting equipment and the use of occupational therapy with patients with back injuries and lower extremity disabilities. The section on upper extremity disabilities has many suggestions for splinting and adaptations of tools. The book belongs in the library of all therapists working with the physically disabled.

—Mary D. Booth, O.T.R.

POSTURAL FITNESS SIGNIFICANCE AND VARIANCES. Charles Leroy Lowman, M.D., Carl Young, Ed.D., Philadelphia: Lea & Febiger, 1960, 341 pp.

The content of this book is organized around the prevalence of irregularities in structural and functional patterns, transitional stages in growth development, maturity and adjustment, and interrelationships of body segments and their importance to efficiency. Dissimilarities which exist among people are discussed and procedural techniques for determining variations. Fundamentals of exercise beliefs are presented as well as individual group planning in terms of needs. The book is directed at school personnel, counsellors, specialists in health, physical education, recreation and rehabilitation, and orthopedic physicians to recognize, refer, prevent or correct postural conditions.

Although the book vividly describes many postural defects and outlines many exercises, it is sparse on illustrating routines for specific involvements. Appendixes A and B give exercise schedules presented in the former publication *Corrective Physical Education for Groups.*

—Lester M. Brower, M.A., O.T.R., R.P.T.

BOOKBINDING MADE EASY. Lee M. Klinefelter, Milwaukee: The Bruce Publishing Company, 1960, 86 pp., $3.00.

This is a revised edition which has added information on: single sheet binding, auxiliary materials, and a new chapter on casing. The new introductory chapter gives a history of bookbinding and the final chapter covers automatic bindery plants. The instructive sections seem very complete. Information is given on equipment and practical and inexpensive materials, repairing and sewing, forwarding, facing and finishing. There are line drawings and photographs to illustrate the step by step instructions.

—Jane Trout, O.T.R.

SCULPTURE? THE BASIC METHODS AND MATERIALS. Lillian Johnson, New York: David McKay Company, Inc., 1960, 90 pp., $3.75.

Lillian Johnson says that anyone with inclination can enjoy doing sculpture. This is a "how to" book for the beginner. The author discusses modelling in plastilene and clay, carving in plaster of paris, wood and stone, giving necessary information on tools, materials, preparation and procedure. Information is included on armatures, casting in plaster, metal sculpture and mobiles. Lists of reference books and where material may be purchased are given. There are many well chosen photographic illustrations of work by the author and others showing examples of work in the media described.

—Jane Trout, O.T.R.

Have You Tried?

Sax-Crafts (Division of Sax Brothers, Inc.) Milwaukee, Wisconsin, distributor and dealer in craft supplies, has been appointed exclusive national distributor for LITHO-SKETCH (a revolutionary new method of making art lithographs from paper plates); the MAJESTIC BRAYER (a highly improved ink roller for use in graphic arts); and the "BRUSH N' HAND CLEANER (a new liquid cleaner for artists' brushes).

The LITHO-SKETCH represents a new idea in lithography. Instead of cumbersome, expensive stones and heavy printing presses, a specially treated paper plate is used in conjunction with an ordinary laundry hand wringer or simply a tablespoon. Ordinary lithographers' tools (crayon or brush) are used. This makes it possible, at low cost, to produce professional-style lithographs. All materials used are non-toxic. Manufactured by Anthony Ensink Company of Chicago, Sax-Crafts is the exclusive distributor to occupational therapists.

The Sax MAJESTIC BRAYER comes in three sizes (2", 5" and 8"). The soft rubber roller retains its even rolling properties during a long lifetime of use. It is impervious to oil, water, turps or temperature changes.

The hardwood handle with solid rivet construction is designed to stand hard wear without loosening up.

"BRUSH N' HAND CLEANER" is a non-inflammable, non-corrosive and non-toxic cleaner which removes oil, casein or tempera paints, whether they be wet or dry. To use, simply place a daub of cleaner in the palm of the hand and work it with the brush which is to be cleaned. Both hand and brush are cleaned simultaneously. The cleaner conditions the hand as it conditions the bristles of the brush. Possessed of extremely long shelf life it is extremely economical for schools, institutions or anyone active in the painter's art. It eliminates soap and water, turpentine or messy liquid cleaners. For details and prices of any of the new products contact Sax-Crafts, 1103 North Third Street, Milwaukee, Wisconsin.

Special features in this redesigned Amaco all-metal kick wheel make it unique. The new free form aluminum worktable is shaped to make a comfortable hip rest for the potter so he is never thrown off balance. Hit tools, sponges, and cutting wire, placed on this hip rest extension, keep them within easy reach at all times. Sturdiness and balance have been improved by converting this wheel from a 3-leg to a 4-leg model.

Regulated speeds for throwing as well as quick starting and stopping are made possible by mechanical precision. The horizontal action treadle is operated by light, easy kicking with the left foot. This in turn propels the 80 pound balanced flywheel which provides the momentum for easy throwing. For price and complete details write AMERICAN ART CLAY COMPANY, 4717 West Sixteenth St., Indianapolis 24, Indiana.

COMING EVENTS . . .

American Hospital Association Institute for Occupational Therapists, Willard Hotel, Washington, D. C., May 15-18, 1961.

* * *

Third World Congress of Psychiatry, Allan Memorial Institute, Montreal, Canada, June 4-10, 1961.

* * *

Thirty-eighth Annual Conference of the American Physical Therapy Association, The Palmer House, Chicago, Illinois, July 2-7, 1961.

The United Cerebral Palsy Research and Educational Foundation, Inc., has again granted the AOTA $10,000 for partial tuition scholarships for undergraduate occupational therapy students. The grant will be effective from July 1, 1961, through June 30, 1962. Awards will be for tuition costs only and will be made to students who, during the above period, are enrolled as juniors, seniors, advanced standing (post-degree) students or in student affiliation. Applicants must have completed one semester in the occupational therapy program. As in the past, applications should be submitted to the student's curriculum director for initial processing. On behalf of the Board of Management and the members of the Association, appreciation for this grant has been forwarded to the Foundation.

Georgia Warm Springs Foundation

GRADUATE COURSE

Physical Therapy and Occupational Therapy

In the Care of *Neuro-Muscular Disease*

This course is open to graduates of approved schools of physical and occupational therapy. Such graduates must be members of the American Physical Therapy Association and/or American Registry of Physical Therapists, or American Occupational Therapy Association.

Entrance dates: First Monday in January, April and October.

Course I—Emphasis on care of convalescent neuromuscular disease with intensive training in functional anatomy, muscle testing, muscle reeducation and use of supportive and assistive apparatus. This course is complete in itself.

Course II—Three months duration with course I prerequisite. Emphasis on care of severe chronic physical handicaps with intensive training in resumption of functional activity and use of adaptive apparatus.

In-Service Training Program—Fifteen months duration at salary of $225 per month plus full maintenance, increasing to $250 per month at the completion of nine months. This program includes training in course I and. II.

Tuition: None. Maintenance is $100 per month. For scholarship to cover transportation and maintenance for course I and II, contact The National Foundation, 800 2nd Avenue, New York 17, N. Y. (Scholarships require two years of experience.)

For further information contact:

ROBERT L. BENNETT, M.D.
Medical Director

Georgia Warm Springs Foundation
WARM SPRINGS, GEORGIA

CLASSIFIED ADVERTISING

Classified advertising accepted for POSITIONS WANTED and POSITIONS AVAILABLE only. Minimum ad $4.00 *for* 3 *lines, each additional line* $1.00. *(Average* 56 *spaces per line.) Classified display, boxed,* $5.00 *per column inch. Copy deadline first of each month previous to publication.*

POSITIONS AVAILABLE

Staff position for registered occupational therapist or eligible graduate, rehabilitation dept. of large, modern tuberculosis hospital. Pleasant suburban location with good transportation, shopping and recreational facilities. 40 hour week, paid vacation and holidays, liberal cumulative sick leave, retirement plan. Full maintenance available at reasonable rate. Opportunities for further education in local universities. Write: Director of Rehabilitation, Sunny Acres Hospital, Cleveland 22, Ohio.

OCCUPATIONAL THERAPISTS for California's progressive programs in state mental hospitals and for physically handicapped children in special schools. Opportunities for imaginative and resourceful therapeutic activities. Eligibility for registration with the national registry of the American Occupational Therapy Association is required. No experience is needed to start at $436 a month. Positions in schools under the Crippled Children Services program are open also to experienced occupational therapists at $481 a month. Attractive employee benefits. Secure details from State Personnel Board, 801 Capitol Avenue, Sacramento 14, California.

Position open for registered occupational therapist in a modern, recently expanded 200 bed general hospital located in a progressive midwestern community. Recently established department now serving eleven bed psychiatric unit. Occupational therapy program to be expanded to include general, medical and surgical patients. Salary open, commensurate with training and experience. Consultation and referrals available from local new rehabilitation center. Apply Elkhart General Hospital, Elkhart, Indiana.

Applications continually accepted for staff therapists in rehabilitation hospital treating children and adults. Addition completed recently includes complete new OT department. Current staff of five is being gradually increased to meet greater in and out patient capacity. Progressive personnel policies. Salary commensurate with experience and training. Location ideal for cultural interests and all sports. Further information and attractive brochure furnished on request. Apply to Administrator, Sunnyview Orthopaedic and Rehabilitation Center, Inc., 124 Rosa Road, Schenectady 8, New York.

Occupational therapist for duties in State Crippled Children's Service. Merit system, retirement benefits, liberal vacation and sick leave. Salary: occupational therapist I without experience, $4,680; occupational therapist II with experience, $5,220-$5,940. Write to: Director, Crippled Children's Service, State Board of Health, Dover, Delaware.

Supervising occupational therapist to head occupational therapy department in a 500 bed teaching hospital. Applicants should have had recent supervisory and administrative experience. Pleasant working conditions. University community. Contact Personnel Office, University of Virginia, 1416 W. Main Street, Charlottesville, Virginia.

Occupational therapist, $4740-$5790, liberal benefits. Comprehensive rehabilitation, 200 patients, all ages. 17 occupational therapists. Large teaching program. Beautiful location 30 miles from New York City. Full maintenance available for single person at $500 per year. Morton Hoberman, M.D., Physiatrist, New York State Rehabilitation Hospital, West Haverstraw, New York.

OCCUPATIONAL THERAPISTS
If interested in LOCATION; Maryland
SALARY: O.T. $4,540.00-$5,677.00
Head O.T. $5350.00-$6688.00
FIELD: Rehabilitation
Write to: Dr. F. L. Mahoney
Director of Rehabilitation Medicine
Montebello State Hospital
2201 Argonne Drive
Baltimore 18, Md.

Do O.T.'s exist? This hospital has unusual advantages to offer members of this vanishing species—a liberal, OT-minded administration; modern occupational therapy building, fully equipped; up-to-date living quarters, complete maintenance $316 per year; large student training program; wide range of craft supplies and activities; a growing program that is outgrowing the present staff; salary—beginning salary based on experience; yearly increment; paid vacations, holidays and sick time; 40-hour week; health insurance and retirement plans, plus social security; state psychiatric, 3000-bed, 50% open-door, average patient stay—3 months, accredited by AMA. Are you interested? Contact Mrs. Virginia Holmberg, O.T.R., Connecticut State Hospital, Middletown, Connecticut.

Experienced registered occupational therapist to operate occupational therapy department for 100 bed psychiatric unit in 800 bed hospital. Salary open. Contact John R. Mote, Administrative Assistant, Methodist Hospital, 1604 North Capitol Avenue, Indianapolis 7, Indiana.

Help wanted female: OTR to head department in large private psychiatric hospital, 35 miles from New York City. Attractive salary. 5 day week. 4 weeks vacation. 7 holidays. Many fringe benefits. Write Box 15, American Journal of Occupational Therapy, 3514 N. Oakland Ave., Milwaukee 11, Wis.

Director—expanding occupational therapy department. Children and adults. Supervision of OT staff and students. Carry out development program. Full information on request. Write: Director, Crotched Mountain Rehabilitation Center, Greenfield, New Hampshire.

OTR with 2 yrs. experience minimum, to work as a team with an M.D., P.T., and public health nurses for rehabilitation program in nursing homes. 40 hour week, 2 wks. vacation, 2 wks. sick leave, retirement plan and social security. Salary range $450-$535 plus travel allowance. Write Elizabeth Gentry, M.D., Ass't. Director, Austin-Travis County Health Dept., 1313 Sabine St., Austin, Texas.

Challenging opportunity for occupational therapist. This is a modern, progressive 370 bed general hospital with new comprehensive rehab. division. Must be able to set up department and must be familiar with pre-vocational evaluation. Salary up to $7,500 per annum. The Methodist Hospital of Gary, Indiana.

Occupational therapist—large medical clinic including 500 bed hospital offers staff occupational therapist position. Five day 40 hour week, liberal benefits, and the most modern facilities. Salary commensurate with qualifications. Direct inquiries to Personnel Department, The Cleveland Clinic Foundation, 2020 East 93rd Street, Cleveland 6, Ohio.

OTR'S wanted for staff positions in a new medically oriented 125 bed rehabilitation center; comprehensive program integrated with large general hospital under supervision of a physiatrist. Salary $4300 up depending on experience. Contact Miss Lucille Viti, O.T.R., Dir. of Occupational Therapy, Moss Rehabilitation Hospital, 13th and Tabor Road, Philadelphia 41, Pa.

A few staff therapists positions are still open for a chronic disease (all ages) and geriatric program in a 2000 bed city hospital and home affiliated with New York Medical College. Positions are available in adult rehabilitation, volunteer ward program, home care, and special studies. Student training program. Seven hour day, five day week, four weeks paid vacation, eleven holidays, twelve days sick benefit, six hour day for summer months. Salary $4250-$5330, (annual increments $180). Write Mrs. Carolyn Aggarwal, O.T.R., Bird S. Coler Hospital and Home, Welfare Island, New York 17, New York.

Occupational therapist position available in modern, well-equipped department in new hospital. Salary open. Forty hour week, 2 weeks vacation, 3 weeks after 5 years, 7 holidays, workmens compensation, sick leave and retirement program. Work in 28 bed psychiatric unit. Apply to Personnel Director, St. Ansgar Hospital, Moorhead, Minn.

Registered occupational therapist, Cheyenne, Wyoming: Newly-established multi-purpose mental health center providing in-patient service, community clinic, consultative educational, training, and community organizational service for 4-county area. (2 years experience), one must be in a mental health setting. Ability to organize and coordinate occupational therapy program in general hospital with psychiatric patients: utilize group work skill, coordinate volunteer services. Capacity and preference for imaginative planning and action. $6000-$7200. Transportation expenses for interview. Mrs. Donald Stanfield, Board of Directors, Southeast Wyoming Mental Health Center, 3816 Capitol Ave., Cheyenne, Wyoming.

Immediate opening for graduate occupational therapist in large rehabilitation center. Treatment program includes functional occupational therapy, activities of daily living and domestic assessment and training, pre-vocational evaluation, industrial therapy. Caseload is varied, including physical and psychiatric disabilities. Salary $3,300-and up, depending on experience. Vacation one month. Contact Miss Constance Lethbridge, Executive Director, Occupational Therapy and Rehabilitation Center, 1031 Ottawa Street, Montreal, P.Q., Canada.

Immediate opening for therapist interested in initiating occupational therapy in an outpatient crippled children's clinic. Brownsville is located on the border of old Mexico and is a short distance from a lovely beach. Salary $4800 up depending upon qualifications. Contact George Odabashian, President, Brownsville Society for Crippled Children, Inc., Box 841, Brownsville, Texas.

Registered OT for new OT dept. in recently opened private pavilion. Integral member of rehabilitation team. One month vacation. Salary from $4200 depending on experience. Apply, Miss Marion Sinz, O.T.R., Director of OT, Home for Aged and Infirm Hebrews, 121 West 105th Street, New York City, Mo-6-2000.

Opening for staff occupational therapist, registered or eligible for immediate registration. Treatment to consist of physically handicapped, emotionally upset, and the evaluation of new patients in an institution for mentally retarded. Institution in same town as University of Florida. Beaches within 100 mile radius. For further information write to Mrs. J. S. Brown, O.T.R., Director of Occupational Therapy Department, Sunland Training Center, Gainesville, Florida.

Occupational therapist wanted. Amarillo Cerebral Palsy Treatment Center. Five day week, three weeks paid vacation, one week at Christmas, plus six other holidays. Hospitalization and life insurance benefits. Beginning salary around $4,600, but is open. Please contact Vincent J. Privitera, R.P.T., Director, Cerebral Palsy Center, 808 Crockett, Amarillo, Texas.

Occupational therapy director—salary $5400-$6720. Hospital of 4600 beds is currently being remodeled and expanded. Liberal sick leave, vacation, holidays and retirement coverage. Apply Personnel Office, Central State Hospital, Petersburg, Virginia.

Registered occupational therapist wanted. 870-bed NP hospital. Hospital located on the beautiful Gulf Coast midway between Biloxi and Gulfport, Miss. Career civil service position. Liberal employee benefits. Salary $5355 to start, with in-grades to $6840. One year experience required. Write Chief, Personnel Division, VA Center, Gulfport Division, Biloxi, Miss.

Wanted: Registered OT for up-to-date progressive home for Jewish aged in Kansas City, Missouri, with 110 residents. Well equipped shop, good budget for supplies. Salary $325.00 per month for new graduate, Monday through Friday, lunches included. Good working conditions, employees' benefits. Apply to Mrs. Lillian Dubansky, Rec. Dept., Home for Jewish Aged, 7801 Holmes Street, Kansas City 31, Missouri.

Staff therapist in private 200 bed psychiatric hospital 23 miles north of New York City. Expanding program in newly opened building. Rural setting. Starting salary $4400. Maintenance available if desired. Three week vacation first year, four weeks thereafter. Contact Harriet Lavoie, O.T.R., St. Vincent's Hospital, Harrison, New York.

Registered occupational therapist wanted (female only), 2000 bed psychiatric veterans hospital, Lyons, N.J. (near Plainfield, N.J.); career civil service; liberal benefits; salary $5355 to $6345. Chance for advancement. Write: Personnel, VA Hospital, Lyons, New Jersey.

Staff occupational therapist. Position available in our 120 bed rehabilitation center. Excellent working facilities for treating children and adults with all types of disabilities. Both in and out-patient work. 40 hour week, vacations, sick leave, holidays, insurance and other benefits. Salary range $4260 to $4800. Attractive industrial city of 200,000 with cultural and recreational advantages. Inquire Personnel Department, Iowa Methodist Hospital, Des Moines, Iowa.

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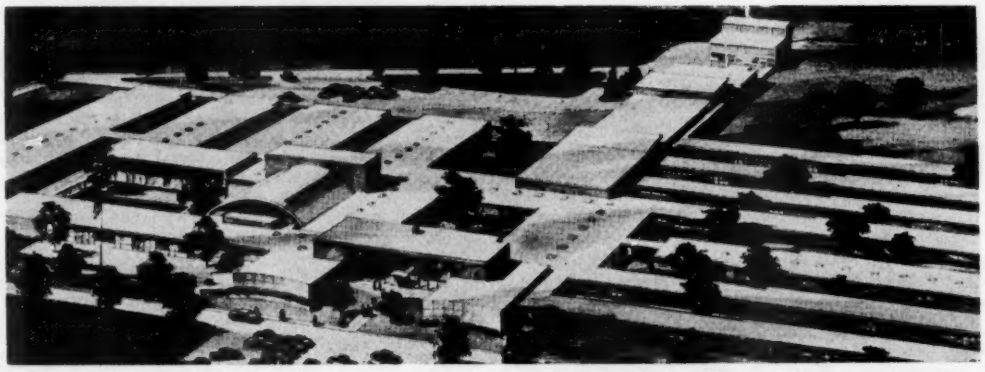

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Challenging opportunity for staff OTR in recently established full comprehensive rehabilitation center. Excellent working conditions. For further information contact Sarah Gephardt, O.T.R., Chief Occupational Therapist, Hot Springs Rehabilitation Center, Hot Springs, Arkansas.

Supervising occupational therapist to direct program in rehabilitation service of large hospital in San Francisco Bay Area. Salary $481-584 month with progressive civil service benefits, including vacation, retirement and sick leave. Alameda County Civil Service, 12th and Jackson, Oakland, California.

Available, for a therapist who is interested in research, a dynamic environment, teaching, personal growth and physical disabilities. Experience not essential. Staff position at teaching center for Albert Einstein College of Medicine. $4250 plus $200 cost of living adjustment. Mrs. Frances L. Shuff, Program Coordinator, Dept. of Rehabilitation Medicine, Bronx Municipal Hospital Center, Pelham Parkway South, Bronx 61, New York.

Registered occupational therapist to assume responsibility for organizing a pioneer, pilot program for a group of five homes for the aged, closely located in proximity, with a total of about 250 residents. Starting salary approximately $6,000 to $6,500, depending upon experience. Immediate need. State education and experience in application. Mrs. William MacFarlane, The Council of Homes of Rochester and Monroe County, Inc., 666 East Avenue, Rochester 7, New York.

Opening September first for chief occupational therapist in 600 bed general medical and surgical teaching hospital. Program includes pediatric, psychiatric, and physical disabilities. Salary open. Three to four weeks paid vacation; sick leave; uniform laundry. Write: Director of Physical Therapy and Occupational Therapy, Box 3247, Duke University Medical Center, Durham, N. C.

Position for registered occupational therapist available at Children's Memorial Hospital. New department with an expanding and challenging program, for patients in a variety of diagnoses. Program includes volunteers and student nurses. Paid vacation plus holidays, sick leave, insurance benefits and free retirement program. Write: Director of Personnel, Richard E. Eyestone, Children's Memorial Hospital, 707 Fullerton Ave., Chicago 14, Illinois.

The rapidly expanding psychiatric program under the direction of the department of psychiatry of Emory University Medical School at Emory University in Atlanta, Georgia, has an immediate opening for a registered occupational therapist with psychiatric experience. Presently the program consists of two intensive-care patient units at Emory University Hospital and Grady Hospital, an out-patient clinic, and a growing resident training program. New developments include a child psychiatric clinic and immediate plans for a large state mental hospital adjacent to the campus for training and experimental programs. Many opportunities for learning and advancement. Weekly team and staff conferences, continuous inservice training, including lecture and patient presentations. Excellent benefits and working environment on the main campus in suburban Atlanta, a cosmopolitan city with a population of over a million. Write: Personnel Office, Emory University, Atlanta 22, Georgia.

Opening for occupational therapist—full time—accredited private psychiatric hospital—70 bed. Located in Westport, Connecticut. (One hour from New York by train or car.) Write or call Hall-Brooke Hospital, Box 31, Greens Farms, Westport, Conn.

Occupational therapist, psychiatric setting supervisory and staff. Eligibility for registration with American Occupational Therapy Association required. A progressive program pioneering new concepts of rehabilitation. Opportunities for imaginative and resourceful therapeutic activities. Salary commensurate with experience and training. Write Personnel Manager, Springfield State Hospital, Sykesville, Maryland.

Wanted: registered occupational therapist. Begin and develop new program in 455 bed general hospital adjacent to college campus. Fringe benefits: vacation, sick pay, health insurance, retirement plan, social security and annual physical. Salary open. Apply: Personnel Office, Ball Memorial Hospital, Muncie, Indiana.

Immediate opening for registered therapist on our occupational therapy staff. We are a fully accredited 250 bed private psychiatric teaching hospital, located 8 miles north of Baltimore, Maryland. Pleasant working conditions. Apply to Mrs. Phoebe Penniman, Director of OT, The Sheppard and Enoch Pratt Hospital, Towson 4, Maryland.

Registered occupational therapist with experience & interest in psychiatry. Beginning salary $385—with experience higher. Complete benefit program. For information write: Personnel Section, Mayo Clinic, Rochester, Minnesota.

Assistant occupational therapist required for large department in Dundee Royal Mental Hospital (760 beds), which is the psychiatric teaching hospital for the University of St. Andrews. The hospital offers valuable pioneering and research experience in occupational therapy, using a wide variety of treatment methods. Good working conditions, and salary in accordance with Whitley Council Scale. Applications, stating age, qualifications and experience, with names of two referees to the Physician Superintendent, Dundee Royal Mental Hospital, Liff, Dundee, Scotland.

Immediate staff opening for registered occupational therapist in new rehabilitation center in 300 bed general hospital. Prefer individual with experience in the area of physical disabilities. 40 hour per week, paid holidays, 3 week vacation plus other fringe benefits. Salary open. Write Mrs. Geraldine R. Richardson, O.T.R., Director Occupational Therapy, Bronson Methodist Hospital, 252 E. Lovell St., Kalamazoo, Michigan.

Immediate opening for staff occupational therapist in 120 bed rehabilitation hospital located between Hartford and New Haven, Connecticut. Expanding program includes treatment of both in and out-patients under the direction of a full time physiatrist. Please contact: Miss Frances B. Hume, O.T.R., Gaylord Hospital and Sanatorium, Wallingford, Connecticut.

Occupational therapists for 3000 bed psychiatric hospital—beautiful Puget Sound area. Newly organized program, new building and latest equipment. Salary range $4368-$5652, plus paid holidays, vacations, retirement plan, social security and group health insurance. Maintenance available at reasonable cost. Contact Personnel Officer, Western State Hospital, Fort Steilacoom, Wash.

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OT to head dept. of rehabilitation center. Presents challenge of multi-purpose program. Also provide consultation to community health groups. 40 hr. 5 day wk; 3 wk. vacation. Salary open based on experience. Write Dir. Curative Workshop, 342 S. Webster, Green Bay, Wis.

Immediate opening for occupational therapist in new outpatient treatment center. Possibility for initiative in organizing and developing OT program. Center located in Georgetown. Contact Richard R. Leclair, Executive Director, Delaware Society for Crippled Children and Adults, Inc., 1324 Market Street, Wilmington 1, Delaware.

Immediate openings for one occupational therapy supervisor and two staff occupational therapists for adult and children's units, and one female staff therapist for adult and adolescent recreation services of progressive psychiatric center associated with University of Michigan Medical School. Four units of intensive treatment of children, adolescents and adults with occupational therapy supervisor on each unit. Student affiliation center. Generous personnel benefits; salary commensurate with experience. Address communications to Personnel Department, University of Michigan Medical Center, Ann Arbor, Michigan.

Wanted: to start May 1. Staff OTR with 1 year experience in physical disabilities to work in large general hospital. Paid vacation, sick leave, salary open. Apply Head of Personnel, St. Luke's Hospital, 11311 Shaker Boulevard, Cleveland 4, Ohio.

Wanted occupational therapist with experience and or training in a work evaluation or diagnostic clinic for handicapped and to perform occupational therapy assignments. Male or female. Age open. Contact Mr. Benjamin J. Pumo, Director of Rehabilitation Services, Toledo Goodwill Industries, 601 Cherry Street, Toledo 4, Ohio.

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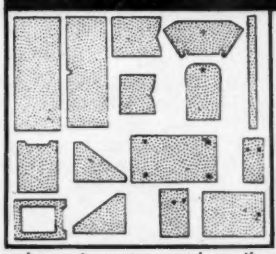

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